Surgery Referral Form

Referral Information

Date: _____

Referring Provider: _____

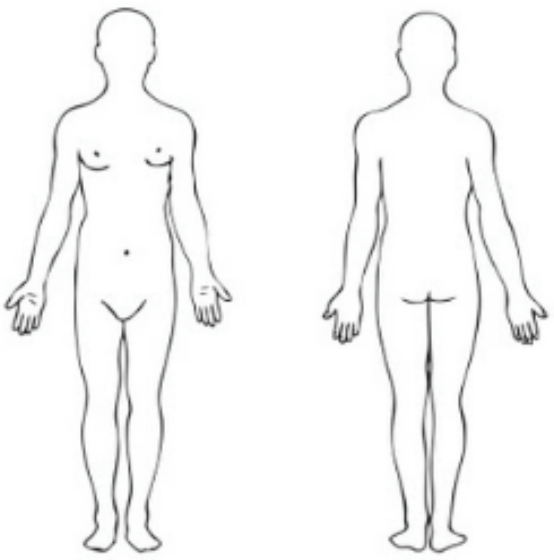
Phone Number: _____

Patient Information

Name: _____

DOB: _____

Phone: _____



Site Information

- ❑ Surgical Consulation Requested
- ❑ Excision Requested
- ❑ Mohs Surgery Requested

Site(s):

A) _____

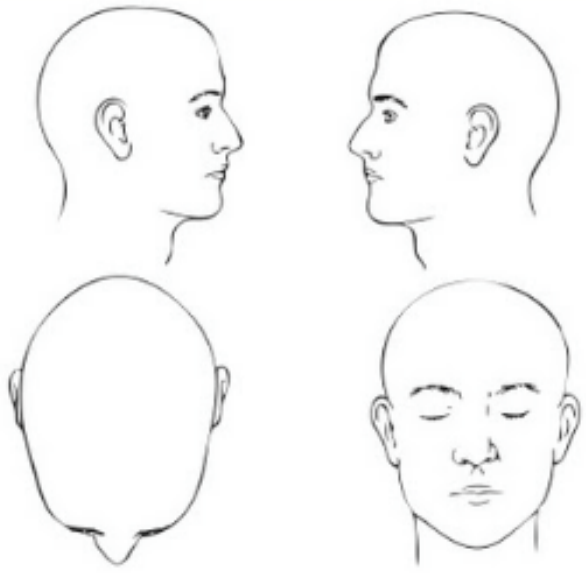
B) _____

Dx(s):

- ❑ Basal Cell Carcinoma
- ❑ Squamous Cell Carcinoma
- ❑ Other

Pathology Performed? ◯ YES ◯ NO

Photos Available? ◯ YES ◯ NO



COMPLETE DERMATOLOGY

Fax to Complete Dermatology, 808-627-6000, or
Email mohs@complete-dermatology.com

****Please include pathology, photos & visit notes****

PHONE: 808-621-1000