Bluegrass Dermatology
Skin Surgery Center, P.S.C.

Patient Referral for Mohs Surgery

Please Print Patient Information:

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **City/State/Zip:** _____

Patient Date of Birth: _____ **Gender:** [ ] Male [ ] Female

Phone (PLEASE INCLUDE 2 CONTACT NUMBERS): ( ) _____ ( ) _____

Referring Physician Information:

Physician's Name: _____ **Person submitting referral:** _____

Phone: ( ) _____ **Fax:** ( ) _____

Please indicate the number (only one lesion per surgery will be removed) and type of lesion(s) along with the location requiring surgery:

_____

If you have any questions or specific requirements when scheduling this patient please call 859-296-4400.

Additional Comments: _____

_____

****We utilize direct mail at Bluegrass Dermatology. Please include the below information and direct mail to HISP address: Chelsea@bluegrass.emadirect.md**

[ ] Path Report/Diagram [ ] Photo(s) of biopsy site(s)

****If you are unable to send direct mail, please e-mail a photo of the patient's biopsy site to surgery@mohs.com. If you do not have a picture of patient's biopsy site, please have the patient take a picture of the site with their cell phone and have them bring it to the office on the day of their surgery**

*****Please fax this form with demographic information and clear copies of front/back insurance cards to: 859-296-4300**

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