

Patient Referral for Mohs Surgery

Patient Information:

Last Name:	First Name:		Middle Initial:
Address:	City/State/Zip:		
Patient Date of Birth:	Gende	r: [] Male [] Female	
Phone (PLEASE INCLUDE 2 CONTACT NUMBERS): Hon	ne ()	Cell ()
Referring Physician Information:			
Provider's Name:			
Person submitting referral:			
Phone: ()	Fax: ()	
Please indicate the number (only one lesion per sthe location requiring surgery:	surgery date will be re	emoved at a time) and	d type of lesion(s), along with
Thank you for the referral. In order to	expedite sched	uling, please ser	nd <u>ALL</u> of the following
with your referral, as we are unable to	schedule until a	II information is	received:
[] Patient demographic information [] Patie [] If no photo(s) taken, the patient's office visit			hoto(s) of biopsy site(s) ath Report(s)
Referrals may be submitted by direct mail (Team note that photos do not transmit properly via fax (TeamThompson@bluegrass.emadirect.md). One your office.	– so, please send ph	otos via email (surge	ry@mohs.com) or direct mail
If you do not have a picture of the patient's biop phone and have them bring it to the office on the		he patient take a pict	ture of the site with their cell
We appreciate the opportunity to collaborate in process, please let us know. Thank you.	the care of your patie	nt. If there is anythir	ng we can do to help with the
Additional Comments:			

Carol B. Thompson, M.D.

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