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Surgery Referral Form

From: ______________________________ ___________________ ___________________
Referring Provider Name | Clinic Name | Clinic Phone Number

[ ] **Patient Name:** ______________________________
[ ] **Date of Birth:** ______________________________
[ ] **Phone number:** ______________________________

Please list the following for each lesion being referred:

Location: ______________________________

Pathology: [ ] BCC [ ] SCC/SCCis [ ] Melanoma [ ] Melanoma in situ

Anticipated Treatment: [ ] Mohs [ ] Excision [ ]Slow Mohs/Staged Excision

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Location: ______________________________

Pathology: [ ] BCC [ ] SCC/SCCis [ ] Melanoma [ ] Melanoma in situ

Anticipated Treatment: [ ] Mohs [ ] Excision [ ]Slow Mohs/Staged Excision

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Location: ______________________________

Pathology: [ ] BCC [ ] SCC/SCCis [ ] Melanoma [ ] Melanoma in situ

Anticipated Treatment: [ ] Mohs [ ] Excision [ ]Slow Mohs/Staged Excision

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Additional Information: Please, check any that apply.
[ ] Lesion is recurrent
[ ] Malignancy is greater than 2cm
[ ] Patient is immunosuppressed
Attachments: Please attach the following:
[ ] Demographics or face sheet so our office can contact the patient
[ ] Pathology Report
[ ] Clinical photo or diagram

Please fax this referral form to Evergreen Dermatology at 541-225-4864. Documents can also be sent via direct mail through EMA to YRipke@evergreenderm.emadirect.md