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EVERGREEN
DERMATOLOGY

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SPRINGFIELD, OR 97477

Surgery Referral Form

From: _____ _____ _____
Referring Provider Name **Clinic Name** **Clinic Phone Number**

I am writing to refer the following patient for:

[ ] Excision
[ ] Staged Excision/Slow Mohs
[ ] Mohs Surgery
[ ] Other_____

Surgery is requested for the following condition(s):

[ ] Basal Cell Carcinoma (BCC)
[ ] Squamous Cell Carcinoma/in situ (SCC/SCCis)
[ ] Melanoma
[ ] Other_____

Patient Information: (ok to skip if face sheet is sent and up-to-date)

[ ] Patient Name: _____

[ ] Date of Birth: _____

[ ] Phone number: _____

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 Smcmaster@evergreenderm.emadirect.md