COLLINS
Advanced Dermatology Institute

MOHS SURGERY REFERRAL

Referring Physician _____ Date of Clinic Visit _____ /_____ / _____

PATIENT'S INFORMATION

Name _____ Date of Birth _____ /_____ / _____

Address _____

Primary Insurance _____ Secondary Insurance _____

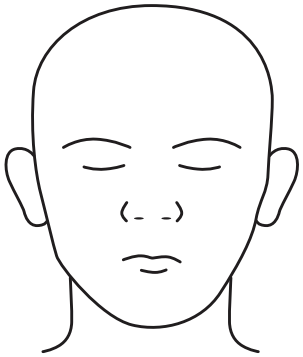
Phone # _____ _____ _____
HOME WORK CELL

Diagnosis ❑ BCC ❑ SCC ❑ Other _____

Diagnosis ❑ Right ❑ Left ❑ Midline _____

Tumor Dimentions _____

Please indicate distribution and dimentions on the diagram if on the face. Attach representative photos if available.



Has a biopsy been performed? ❑ Yes ❑ No

If yes, please attach a copy of the pathology report.

MEDICAL HISTORY

Allergies _____

The patient requires antibiotics before ❑ Surgical Procedures ❑ Dental Procedures

The patient takes ❑ ASA ❑ NSAIDs ❑ Warfarin ❑ Piavix
❑ Other blood thinner, specify _____

The patient has a ❑ Pacemaker ❑ Implantable Cardiovascular Defibrillatorr (ICD)

Additional history/notes _____

_____

_____

REPAIRS

❑ Other Physician ❑ Telephone ❑ Fax

_____ _____ _____

REFERRING PHYSICIAN

Printed Name _____ Signature _____

Address _____ Specialty _____

Phone _____ Fax _____