VALLEY SKIN CANCER SURGERY

Dermatologic and Mohs Micrographic Surgery

Dr. Katherine Lim Quan
Dr. Jill McKenzie

PHYSICIAN REFERRAL FORM FOR MOHS / DERMATOLOGIC SURGERY

Referring Provider: ______________________________ **Phone #:** __________________

Fax #: __________________

Patient Name: ____________________________________ **DOB:** __________________

Phone #: ________________________

Thank you for your referral to our office. In order to better treat your patient, the following information will be needed in order to schedule. Please fax all requested documentation below to 480-821-0888. Unfortunately, without this information we will not be able to proceed with scheduling.

- **Patient Registration**
- **Medical History**
- **Insurance Card (Front and Back)**
- **Medical Note (from biopsy day)**
- **Pathology Report**
- **Diagrams**
- **Picture of site (if taken)**

Site One:

○ Basal Cell Carcinoma ○ Other ___________________________

○ Squamous Cell Carcinoma

○ Site _____________________________ ○ Size _____________ ○ Primary ○ Recurrent

Site Two:

○ Basal Cell Carcinoma ○ Other ___________________________

○ Squamous Cell Carcinoma

○ Site _____________________________ ○ Size _____________ ○ Primary ○ Recurrent

Site Three:

○ Basal Cell Carcinoma ○ Other ___________________________

○ Squamous Cell Carcinoma

○ Site _____________________________ ○ Size _____________ ○ Primary ○ Recurrent

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