

Surgery Referral Form

Referral Information

Date: _____

Referring Provider: _____

Phone Number: _____

Patient Information

Name: _____

DOB: _____

Phone: _____

Site Information

- Surgical Consultation Requested
- Excision Requested
- Mohs Surgery Requested

Site(s):

A) _____

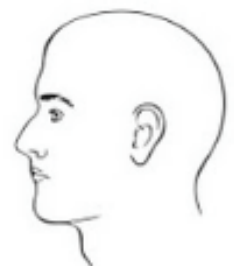
B) _____

Dx(s):

- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Other

Pathology Performed? YES NO

Photos Available? YES NO



Fax to Complete Dermatology,
808-627-6000, or Email

mohs@complete-dermatology.com

****Please include pathology, photos &
visit notes****

PHONE: 808-621-1000

