Valley Skin Cancer Surgery

Dermatologic and Mohs Micrographic Surgery

Dr. Katherine Lim Quan
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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 ***REQUIRED*** –EMAIL to MOHS@EVDERM.COM OR MAIL COPY TO 1100 S DOBSON RD # 223 CHANDLER 85286**

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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