MOHS FAX REFERRAL REQUEST **DATE:_____** **Number of Pages:_____**

BOSWELL DERMATOLOGY

Phone: **559.439.3000**|Referral Fax: **559.435-3229**
5701 N. West Ave|Fresno, CA 93711|www.boswelldermatology.com

Jared Lund, MD, FAAD, FACMS

Fellowship-trained Mohs Surgeon through the American College of Mohs Surgery

Fax this form to make a referral for MOHS SURGERY

Referring Physician: _____ Phone:_____

Patient Name: _____

Patient Home Phone: _____ Patient Cell: _____

Diagnosis (required):

- ☐ Basal cell carcinoma
- ☐ Squamous cell carcinoma
- ☐ Other (AFX, MFH, sebaceous carcinoma, melanoma in situ):

_____

Anatomic site (as named on biopsy report):_____

REQUIRED PATIENT INFORMATION

- ☐ Copy of pathology report
- ☐ Photo of biopsy site (if available)
- ☐ Copy of patient insurance card and demographics
- ☐ Copy of last chart notes

NOTE: ***All information is needed to schedule an appointment***

Special Instructions: _____

_____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

Appointment Date: _____ Time: _____ Contact Person: _____

Following MOHS surgery, your patient will be directed to return to your office for routine dermatologic care.

Thank you for referring your patient to our office.