

DEPARTMENT OF DERMATOLOGY - SURGERY REFERRAL
FAX THIS COMPLETED FORM TO 415-353-7838

Patient Name, Complete Address, Date of Birth	Patient Phone Number	Referring Physician, Complete Address, Contact Phone Number

SPECIAL NEEDS OF PATIENT Translator Needed Language: _____ Non Ambulatory Other: _____

SERVICE REQUESTED: Mohs surgery excision consult other: _____

DIAGNOSIS: BCC SCC Melanoma other: _____

HISTOLOGIC SUB-TYPE (if known): _____

PATHOLOGY NUMBER: _____ **FAX A COPY OF PATHOLOGY REPORT TO 415-353-7838.**

HISTORY: Primary Recurrent Incomplete Excision (also melanoma re-excision)

EXACT LOCATION: Right Left Site: _____ See below. **SITE MUST BE NOTED.**

SIZE: _____ cm

PRIOR TREATMENTS: LN2 Excision Radiation Mohs
 C & E 5 FU Aldara Other _____

OTHER FEATURES: HIV/AIDS Organ Transplant Multiple Tumors Poorly Defined
 Other Immunosuppression _____ Genetic Syndrome Other _____

Indicate location and measure distance to stable anatomic landmark.

