CHAPEL HILL DERMATOLOGY

By DOCS Dermatology Group

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(select option 1 for scheduling then option 3 for Mohs)

Fax: (919) 967-1674

Mohs Patient Referral Form

Date of Referral: _____ **Referring Physician:** _____

Referring Physician Phone: _____ **Fax:** _____

Please Print Patient Information:

Last Name: _____ **First Name:** _____ **MI:** _____

Patient DOB: _____ **Patient Phone:** _____

Address: _____ **City/State/Zip:** _____

Insurance: ☐ Aetna ☐ Blue Medicare ☐ BCBS of NC ☐ Cigna
☐ Tricare ☐ UHC of NC ☐ Other: _____
If "Other," referral acceptance is subject to verification prior to scheduling.

Clinical Information

SITE 1

☐ Basal Cell Carcinoma ☐ Other: _____
☐ Squamous Cell Carcinoma

Site: _____ Size: _____ ☐ Primary ☐ Recurrent

SITE 2

☐ Basal Cell Carcinoma ☐ Other: _____
☐ Squamous Cell Carcinoma

Site: _____ Size: _____ ☐ Primary ☐ Recurrent

Additional Comments: _____

Thank you for your referral to our office. To provide the best care for your patient, the following information is required to schedule an appointment: **please fax this form along with demographic information, clear copies of the front and back of insurance cards, and any supporting documentation to (919) 967-1674, email it to Chapel-Hill_MOHSVM@docsdermgroup.com, or submit via EMA direct mail to Staci Small.**

☐ Pathology Report ☐ Diagrams ☐ Site Photo(s) ☐ Encrypted Color Biopsy Photo