REFERRAL FORM
(256) 705-3105 fax

Patient Name____Birthdate________________________

Address____

Patient Phone___________________________Insurance Company__________________________________

Policy Number__________________________ Group Number_____________________________________

Subscriber Name (or self)_______________________________Subscriber Birthdate____________________

Requesting Physician____

Reason for Referral____

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If previously treated by you, please provide details/medications_______________________________________

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***If for MOHS or EXCISION, please complete the following to assist us in scheduling appropriately:

1. Please include pathology report (if biopsied) ☐

2. Greatest dimension of original lesion if known (not *biopsy* size): ☐ < 1.0 cm ☐ 1.0-1.9 cm ☐ 2.0 - 2.9 cm ☐ > 3.0 cm

3. Recurrent/Previously treated? ☐ YES ☐ NO

4. Location: ☐ Ear ☐ Nose ☐ Lip ☐ Eyelid ☐ Other_________________________

Thank you for entrusting the care of your patients to our team! Should you have any questions or need to provide further information, please call us directly.

Southeastern Skin Cancer & Dermatology
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(256) 705-3000 – SoutheasternSkin.com