256.705.3000 104 J.E. BRISCOE WAY MADISON, AL 35758 SOUTHEASTERNSKIN.COM

256.705.3105 - fax

Referral Form

Patient Name: DOB: / /

Patient Address:

Patient Email:

Patient Phone:

Insurance Company:

Policy Number: Group Number:

Subscriber Name (or self): Subscriber DOB: / /

Requesting Physician

Reason for Referral

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 ☐ 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.