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MOHS SURGERY REFERRAL FORM

Department of Dermatology
 Box 800718 - Charlottesville, Virginia 22908
 Mark A. Russell, M.D. - Julia K. Padgett, M.D.
 434-924-5115 434-924-5936 (fax)

PLACE LABEL HERE.
 IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Referral Information

Date of Referral: _____ Appointment Date: _____ UVA Scheduler: _____
 Referring Physician: _____ Referring Physician Tel #: _____
 Primary Care Physician: _____ PCP Tel #: _____

Patient Information

Patient Name: _____ DOB: _____
 Phone #: (home) _____ (work) _____ (mobile) _____
 Insurance: (primary) _____ (secondary) _____ Referral Needed? YES / NO
 Patient Address: _____

Lesion Information

#1: Type: _____ Location: _____ Size: _____ Prev. Therapy: _____
 Biopsy Information: Date: _____ Lab: _____ Path #: _____
 #2: Type: _____ Location: _____ Size: _____ Prev. Therapy: _____
 Biopsy Information: Date: _____ Lab: _____ Path #: _____

Please mail or fax this sheet, along with the pathology report, prior to the patient's appointment. Include the glass slide of the biopsy if possible. Mark tumor location below:

