INTEGRATED SKIN INSTITUTE

Mohs Surgery Referral Form

Fax: 615-622-8905 Phone: 615-314-1699
integratedskin.org

Referring Dermatologist or Physician/Provider:

Name _____ **Phone:** _____ **Fax:** _____

Patient Information:

Name _____ **DOB** _____ **Phone** _____
Address _____
City _____ **State** _____ **Zip** _____

Primary Care Provider: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance _____
Member ID/Policy: _____ Member ID/Policy: _____

***Skin Cancer Information*:**

Diagnosis(es):
Location(s):

Any Prior Treatments since biopsy?

Patient Smoking (tobacco) History: active / former / none / unknown

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1.) FAX this form (to 615-622-8905) with the following:
- Health insurance card(s) -Demographics Sheet -Pathology Report -Previous Progress Note

2.) EMAIL (if available) photos(s) of site to: photos@integratedskin.org
In the subject of email please state: "Biopsy Mohs Photos - Patient Last Name, Patient First Name. DOB