Bluegrass Dermatology
Skin Surgery Center, P.S.C.

Patient Referral for Mohs Surgery

Please Print Patient Information:

Last Name: ____________________________________ **First Name:** ______________________________ **Middle Initial:** ___________

Address: ____ **City/State/Zip:** ____________________________________

Patient Date of Birth: ____ **Gender:** [ ] Male [ ] Female

Phone (**PLEASE INCLUDE 2 CONTACT NUMBERS**): Home (   ) ____________________ Cell (   )____________________

Primary Insurance Name__________________ ID#________________________________GRP#________________________

Secondary Insurance Name__________________ID#________________________________GRP#________________________

Referring Physician Information:

Physician's Name: ______________________________________ **Person submitting referral**: _________________________________

Phone: (   ) _______________________ **Fax:** (   ) _______________________

Please indicate the number (only one lesion per surgery will be removed) and type of lesion(s) along with the location requiring surgery:

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If you have any questions or specific requirements when scheduling this patient please call 859-296-4400.

Additional Comments: ____

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****We utilize direct mail at Bluegrass Dermatology. Please include the below information and direct mail to HISP address: Chelsea@bluegrass.emadirect.md**

[ ] Path Report/Diagram   [ ] Photo(s) of biopsy site(s)

****If you are unable to send direct mail, please e-mail a photo of the patient's biopsy site to surgery@mohs.com. If you do not have a picture of patient's biopsy site, please have the patient take a picture of the site with their cell phone and have them bring it to the office on the day of their surgery**

*****Please fax this form with demographic information and clear copies of front/back insurance cards to: 859-296-4300**

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