

**Mohs Referral from Outside Office**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Is this a new patient to Houston Dermatology Specialists?  Yes  No

Pathology Report Enclosed

No Pathology Available

1. \_\_\_\_\_  
Diagnosis Location Date of biopsy

2. \_\_\_\_\_  
Diagnosis Location Date of biopsy

3. \_\_\_\_\_  
Diagnosis Location Date of biopsy

Referring Physician Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ After Hours Contact: (\_\_\_\_) \_\_\_\_\_

Office Contact Name \_\_\_\_\_

**For Houston Dermatology Specialists Use Only**

Received By: \_\_\_\_\_ Date Received: \_\_\_\_\_

Circle if Applicable: Pace Maker / Heart Valve / Artificial Joints / Blood Thinner \_\_\_\_\_

Patient is scheduled for: \_\_\_\_\_

Completed By: \_\_\_\_\_ Date Completed: \_\_\_\_\_