

Premier Dermatologic Surgery, P.A.
Elizabeth A. Spenceri, M.D.
 Referral Fax Form

Today's Date: _____

Referring Provider: _____

- Patient Name: _____
- New Patient Prior Mohs patient
- Insurance: _____
- Phone number: _____
- Date of birth: _____

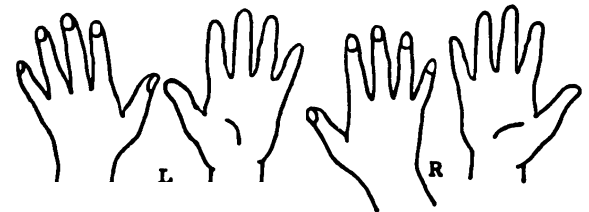
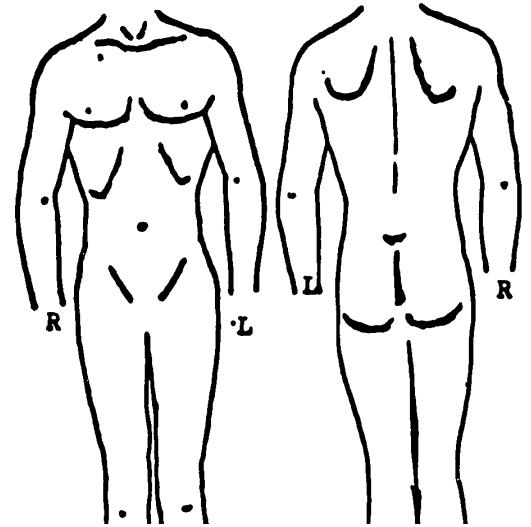
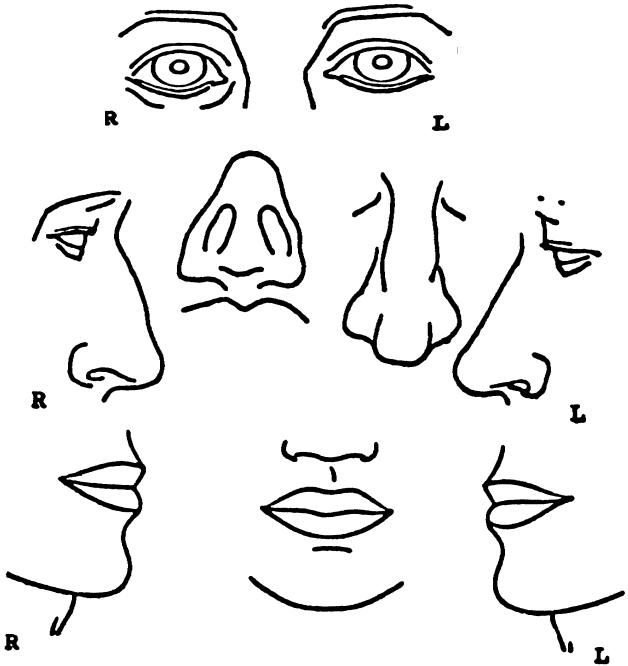
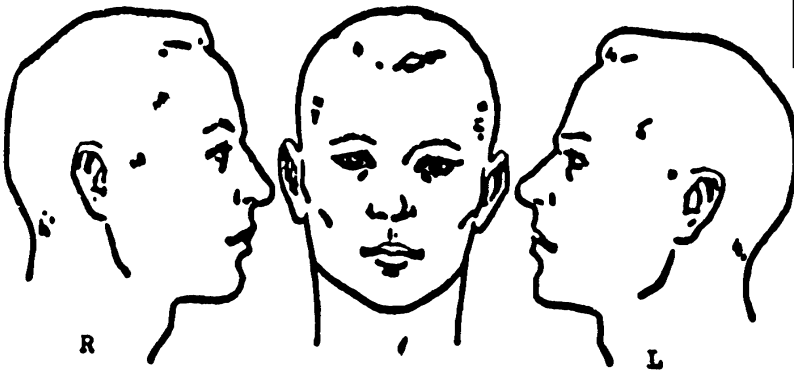
Tumor type/Location:	Approx. Size:
1. _____	_____
2. _____	_____
3. _____	_____

Needs biopsy Location: _____
 Suspected Diagnosis: _____

Please schedule consultation before surgery

May be candidate for coordinated repair

Please mark the location of the tumor(s) and list the tumor type:



Comments:

Please **FAX** this form, pathology report(s) and copy of insurance card to our office: **(913) 327-1119**.

Thank you for allowing us the opportunity to care for your patient.

www.premierdermsurgery.com

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