

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

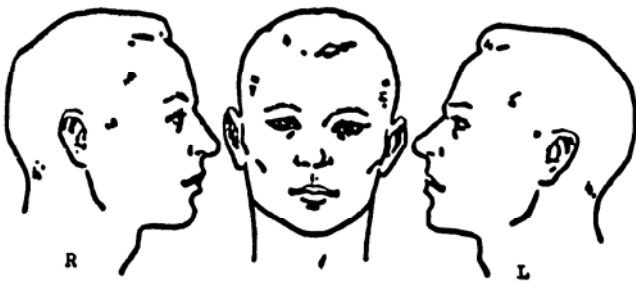
Today's Date: _____

Referring Provider: _____

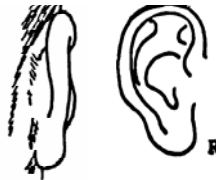
- **Patient Name:** _____
- **Insurance:** _____
- **Phone number:** _____
- **Date of birth:** _____

Tumor type/Location:	Aprox. Size
1. _____	_____
2. _____	_____
3. _____	_____
<input type="checkbox"/> Needs Biopsy Suspected Diagnosis: _____	
<input type="checkbox"/> Patient Prefers Same Day Consult/Surgery	
Comment: _____ _____ _____	

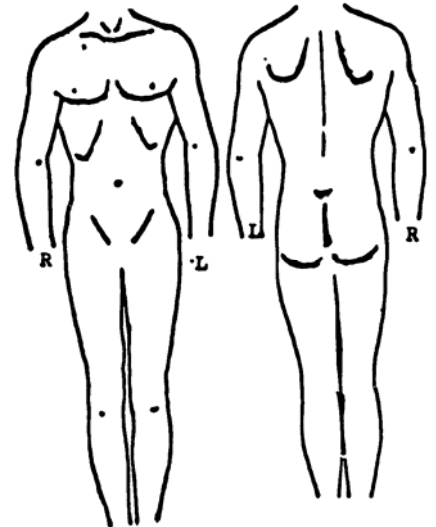
Please mark the location of the tumor(s) and list the tumor type:



Left Ear



Right Ear



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

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

www.premierdermsurgery.com

Premier Dermatologic Surgery, P.A. • Elizabeth A. Spenceri, M.D.

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