

Mohs Surgery Referral Form
FAX TO: 504-988-1965
For Completion by the Referring Physician

I wish to refer my patient to Dr. Alan Lewis with the Tulane Cancer Center for a Mohs surgery evaluation and procedure as appropriate.

*Certification Statement: I have received authorization from this patient to release the information below and to permit the staff of the Tulane Cancer Center to contact him/her directly for follow-up.
(Physician signature required below)*

Physician Signature: _____

Date: _____

Patient Information

Name: _____ Telephone: _____
 Address: _____ SS #: _____
 _____ Date of Birth: _____

Referring Physician Information – Please Provide For Correspondence Regarding Patient

___ PCP ___ Specialist* *Medical Specialty: _____

Name: _____

Address: _____

Phone: _____

Fax: _____

Services Requested- Check Applicable Items

Mohs with Repair by Dr. Lewis []

Mohs with Repair by Referring Physician []

 Pathology report **Included** []

Notes to Mohs Team: _____

PCP: please provide referral # for managed care patients:

Primary Insurance Company: _____

Plan ID #: _____

Group ID #: _____

Insurance Phone Number: _____

Insured Name: _____

Insured DOB: _____

To be completed by Mohs Team

Consultation Date: _____

Tentative Mohs Date: _____

Secondary Insurance Company: _____

Plan ID #: _____

Group ID #: _____

Insurance Phone Number: _____

Insured Name: _____

Insured DOB: _____

Please fax the pathology report with this referral form

You will receive a fax confirmation upon receipt of this request by the Mohs Team

Fax Referral form to: (504)-988-1965

This form contains confidential information intended only for the recipient