Mohs Patient Referral Form

Blanchard Valley Medical Associates, Inc.
Dr. Chase Scarbrough
(419) 427-1393

Date of Referral: _____/_____/_____

Referring Physician Name: _____

Referring Physician Phone: _____ Fax: _____

Patient Demographic Information

Patient Last Name: _____

Patient First Name: _____ Patient Middle Initial: _____

Patient Date of Birth: _____/_____/_____

Patient Address: _____

Patient City: _____ Patient State: _____ Patient Zip: _____

Patient Phone: (*Please mark an X to indicate the preferred contact number.)*

☐ Home: _____ ☐ Cell: _____ ☐ Work: _____

Clinical Information

Type of problem patient is experiencing: _____

_____

Type of Tumor: _____

Location of Tumor: _____

Size of Tumor: _____

Special Notes: _____

_____

Please send the following attachments with this Referral Form:

⇒ Copy of insurance card(s) - Include front and back of primary and secondary (if applicable)
⇒ Office / progress notes related to clinical information above
⇒ Photo of surgical site(s) or diagram(s) - (if available)
⇒ Copy of pathology report(s) pertinent to surgical site(s)
☐ Check here if no biopsy has been performed

Fax completed form and attachments to:
(419) 427-1888

Our staff will contact your office to communicate appointment information once the patient is scheduled.