KNOXVILLE INSTITUTE OF DERMATOLOGY

Mohs/Surgery Consultation Request Form

Date:_____-_____-_____

Referring Physician:_____

Office Contact:_____

Office Phone:_____

Office Fax:_____

Patient Name:_____

Date of Birth: _____-_____-_____

Please be sure to send the following:

- ☐ Demographics
- ☐ Copy of insurance card[s]
- ☐ Office note
- ☐ Pathology report
- ☐ Fax or email photo

It is very important that we receive a photo of the biopsy site

Address:_____

Phone:_____ Alternate Phone:_____

SSN:_____-_____-_____ Sex: M F

Insurance:_____ Member ID:_____

Secondary:_____ Member ID:_____

Diagnosis and site:

_____

_____

_____

Please fax all the above requested information to 865-507-1226 Attn: Manda
If possible, please email a photo of the biopsy site to referrals@dermatologyknoxville.com

If you do not have a secure email, please notify me and I will email you a message that will encrypt your reply.

If you are unable to email the photo, please fax along with the records. If you have any questions, please contact the pathology department at 865-450-9361 option 4.

Thank you so much for your referral!
We look forward to making an addition to the exemplary care you provide to your patient.