COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Fax Cover Sheet for Referrals

Matthew J. Mahlberg, M.D.
Dermatologic Surgery
Phone: (303) 761-0906
Fax: (303) 761-0907

Date: _____

To: **Matt Mahlberg, M.D.**

Attention: **Surgery Coordinator**

Phone: **(303) 761-0906**

Fax: **(303) 761-0907**

From:_____

Phone:_____

Fax: _____

****Please include a copy of any relevant clinical notes, pathology report, patient demographics, insurance details (including a copy of the front & back of the card(s), if available), and photo of the biopsy site.****

Patient Name: _____ DOB:_____

Patient Phone Number: _____

Diagnosis: BCC SCC Melanoma Keloid Scar Revision Other _____

Location: _____ Size: _____

Reason for Referral: Mohs Micrographic Surgery
Excision
Other _____

Follow-up with referring provider: 1 week 1 month 3 months 6 months other_____

Comments: