

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.**

From: _____

Attention: **Surgery Coordinator**

Phone: _____

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

Fax: _____

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

****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:

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