COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Matthew J. Mahlberg, MD | Scott J. Mahlberg, DO
Dermatologic Surgery
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Fax Cover Sheet for Referrals (Procedural)

ATTENTION: Surgery Coordinator
Email: referrals@coloradodermatology.com
Fax: 303-761-0907

Date: _____

Refer to: ☐ First Available ☐ Matthew J. Mahlberg, MD ☐ Scott J. Mahlberg, DO

Referring Clinic: _____

Referring Provider: _____

Sender Phone: _____ **Sender Fax**: _____

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****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 photos****

Patient Name: _____

Patient D.O.B.: _____ **Patient Phone Number**: _____

Patient Email: _____

Patient Address: _____

City/State/Zip: _____

Patient Insurance Carrier: _____

Insurance Member ID 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 month Other:_____

Comments: _____