MICHAEL H. SWANN, MD
MOHS SURGERY & COSMETIC DERMATOLOGY
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MOHS / PROCEDURE REFERRAL FORM

Fill out all pertinent information above the thick gray line.
Fax this form along with pathology results to **(417) 889-0476**

REFERRING ______________________ REF. PHONE# ______________ REF DATE ______________

PATIENT NAME ______________________ DOB ______________ SS# ______________

ADDRESS ______________________________ PHONE (H) ______________

PRIMARY CARE PHYSICIAN: ______________________ PHONE (W) ______________

IF NOT FOR MOHS SURGERY, CIRCLE REFERRAL TYPE: PHONE (C) ______________

CONSULT ***EXCISION*** ***PDT*** ***LASER/COSMETIC***

To Be Filled Out By Referring Provider			*for Swann Dermatology Surgery Staff*
1. *location*	diagnosis	(comments)	*appointment scheduled*
		please check if ☐ *lesion has NOT been biopsied*	*date* time
2. *location*	diagnosis	(comments)	
		please check if ☐ *lesion has NOT been biopsied*	*date* time
3. *location*	diagnosis	(comments)	
		please check if ☐ *lesion has NOT been biopsied*	*date* time
4. *location*	diagnosis	(comments)	
		please check if ☐ *lesion has NOT been biopsied*	*date* time
anticoagulants ☐ NOT ON BLOOD THINNERS ☐ PT. IS ON THINNERS: ______________			*Anticoagulant Instructions*
other medical conditions ☐ ______________			

Sched. Notes: ______________ *Date(s) Pt. Called* ______________ *Appt(s) sched by* ______________

Packet Sent Date ______________

☐ Do not wear make-up ☐ Bring 1-person to drive ☐ Bring a book & snack ☐ 45-60min between layers ☐ under local anesthesia ☐ repair options

Primary Insurance ______________________ **Eligability**

policy# ________ phone# ________ Effective Date: ________

group# ________ group# ________ Deductible: ________

Secondary Insurance ______________________ Co-Pay: ________

policy# ________ phone# ________ Co-Inusrance: ________

group# ________ group# ________ Verified by: ________