Mohs Micrographic Surgery Patient Referral Form

Patient Name (Last, First):_____

Date of Birth (mm/dd/year): _____

Patient phone #: _____

Diagnosis: _____

Location(s): _____

Path report/photos attached: ☐ Yes ☐ No

Once we receive the fax referral, we will contact your office to obtain the clinical photographs in a HIPAA You may also email our office directly at dermsurg@ohsu.edu to attach photographs.

Referring provider: _____

Referring office contact information (if necessary):

Phone: _____ Fax: _____

Email: _____

Referral for: ☐ Mohs Micrographic Surgery
☐ Excision
☐ Consult _____

☐ Anna Bar, M.D. ☐ Justin Leitenberger, M.D.
☐ Wesley Yu, M.D. ☐ Surgical Fellow
☐ First Available

Oregon Health & Science University
Department of Dermatology
Dermatologic Surgery

T: 503 494-6483

F: 503 494-0596

E: dermsurg@ohsu.edu

Mail code: CH5D
3303 SW Bond Avenue
Portland, Oregon 97239-4501
www.ohsu.edu/dermatology

Surgery Faculty

Anna A. Bar, M.D.
bara@ohsu.edu

Justin J. Leitenberger, M.D.
leitenbe@ohsu.edu

Wesley Yu, M.D.
yuwe@ohsu.edu