MOHS SURGERY REFERRAL FORM

Please fax this form to 205.930.1870

☐ MAIN OFFICE: WOODWARD BUILDING
1927 1st AVE. North, STE 300
Birmingham, AL 35203

☐ GARDENDALE LOCATION
931 Sharit Avenue, STE 201
Gardendale, AL 35071

Patient Name: _____ Date: _____

Patient Date of Birth: _____ Parent/Legal Guardian: _____

Contact Phone #: _____ Patient Email: _____

Patient Insurance: _____ _____ _____
Insurance Provider | Contract # | Group #

Reason for referral/consult:

PROVIDER REQUEST:

- ☐ C. Blake Phillips, MD
- ☐ Callie R. Hill, MD
- ☐ First Available

REQUIRED DOCUMENTS:

- ☐ Pathology
- ☐ Visit Notes
- ☐ Insurance Card
- ☐ Photos

(email photos to courtney@totalskinandbeauty.com

Referring Provider: _____

Sent by (Person sending this form): _____ # of pages (inc. cover sheet): _____

Referring Phone Number: _____ Referring Fax Number: _____

DR. PHILLIPS SURGERY SCHEDULER
Courtney Holtbrooks
Phone: 205.380.6136
Email: courtney@totalskinandbeauty.com
Fax: 205.930.1870

DR. CALLIE HILL SURGERY SCHEDULER
Alison Garnett
Phone: 205.380.6115
Email: Alison@totalskinandbeauty.com
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EMA Direct: chutcheson@totalskin.emadirect.md