FOREFRONT DERMATOLOGY®

MOHS / EXCISION SURGERY REQUEST FORM

Dr. Andrew Villanueva

Virginia Beach, VA *(First Colonial Rd.)* **• Chesapeake, VA • Kitty Hawk, NC**

Today's Date:_____

Patient Name: _____ DOB:_____

Home Phone: _____ Cell Phone: _____

Address: _____

Insurance: _____ ID# _____

Diagnosis	**Location**	**Size**	**Date of Bx**
1.			
2.			
3.			

COMMENTS: _____

_____

Requesting Physician: _____

PHONE: _____ FAX: _____ EMAIL: _____

Preferred method of referral is via email at vbmohs@forefrontderm.com. If unable to email, fax referral to ***1-757-333-8002****. Please allow a minimum 2-week timeframe for our Mohs team to review referral and to contact the patient for scheduling. If the patient is in your office and you need immediate service, call our Mohs Specialty Team at* ***1-757-538-2962.*** *Please* ***provide a copy of the pathology report, patient demographic sheet, and picture or map of surgical site with your referral****. We will contact the patient to schedule, provide pre-operative instructions, and driving directions.*

Updated: 12/2023