



## SURGERY REQUEST FORM

Provider: Rachel Pflederer, MDLocation: Mountain BrookAppointment Type:  Mohs  Excision
**REQUESTING PHYSICIAN/HEALTH CARE PROFESSIONAL (HCP) INFORMATION:** PLEASE PRINT CLEARLY

Date of Biopsy			
Surgical Site			
Diagnosis			
Referring Physician/HCP			
NPI Number			
Address/Zip Code			
Phone Number		Fax Number	
Name of Person Completing Form			

**PATIENT INFORMATION:** PLEASE PRINT CLEARLY

Patient Name				
Date of Birth		Patient Email		
Address/Zip Code				
Cell Number		Alternate Number		
Insurance Company		Contract #		Group #
Secondary Insurance		Contract #		Group #
Primary Card Holder Name				Date of Birth

Please include chart notes, insurance card, path report, pictures, and diagrams. All major insurances accepted.

Please fax surgery consult form to 205.820.5064

HISP address for secure messaging: [flacy@villagedermatology.emadirect.md](mailto:flacy@villagedermatology.emadirect.md)

Attention: Fletcher Lacy

Upon receipt of surgery consult form with required documentation, we will contact and schedule your patient within 48 hours. If you have any questions, please contact our Referral and Surgery Specialist at 205.877.9773. For additional forms or to complete this form online, go to [villagedermatology.net/physician-referral-form/](http://villagedermatology.net/physician-referral-form/)