

THE SKIN CANCER SURGERY CENTER

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Patient Referral

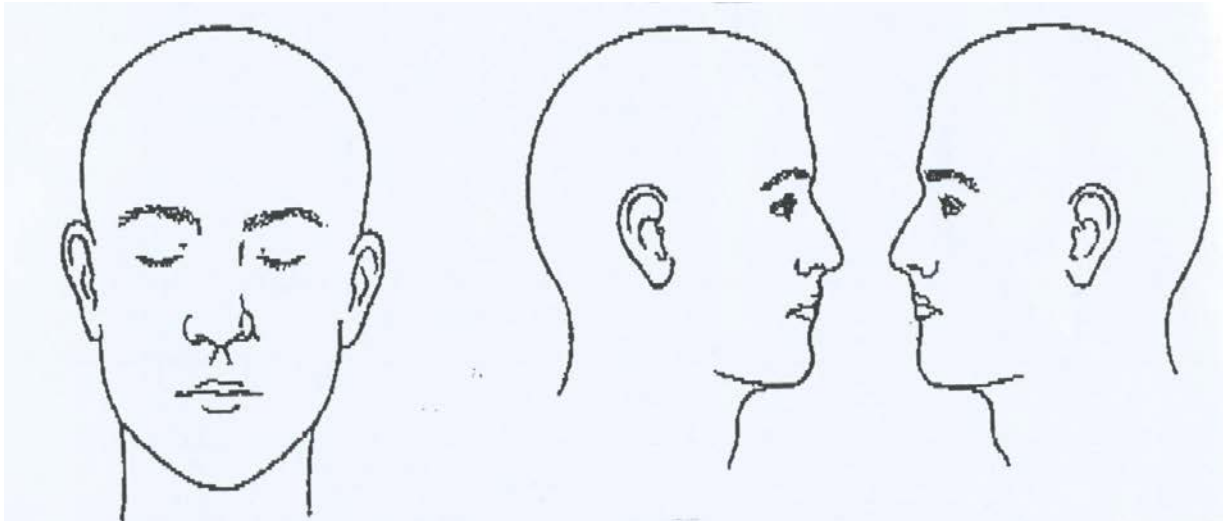
Please provide the following information and attach a copy of the pathology report

Date: _____

Patient's Name: _____

Diagnosis & Location: _____

Notes:



Please fax to (301) 564-6391

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