Dartmouth Health | Dartmouth Geisel School of Medicine

Dartmouth Cancer Center

Phone: (603) 650-7901
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Comprehensive Melanoma Team

Management of Care:

❑ Surgical ❑ Medical Oncology ❑ Radiation Oncology

❑ Dermatology ❑ Second Opinion

❑ Other: Specify _____

_____

Presenting Symptom/Diagnosis:

Anatomic Location: _____

_____

Breslow Depth: _____

_____

Mitotic Rate: _____

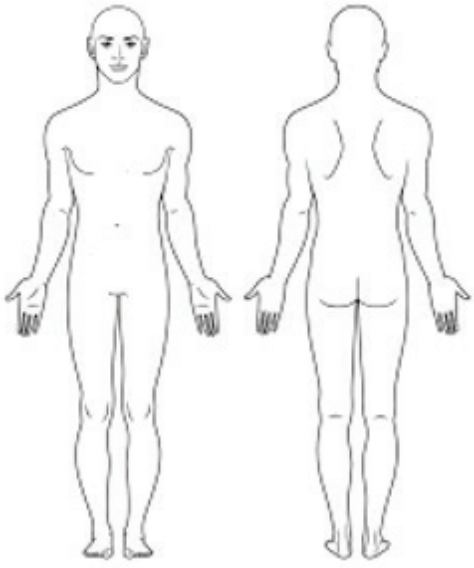
_____

Ulceration Status: _____

_____

Transected at the base: ❑ No ❑ Yes

Transected at periphery: ❑ No ❑ Yes



History of Melanoma: ❑ No ❑ Yes If so where:

Information Required

All office notes, operative reports, lab reports, imaging reports, and pathology reports: Fax to: (603) 640-1909

Pathology slides: Mail/Ship to Pathology Department, DHMC, One Medical Center Dr, Lebanon, NH 03756