ST. JOSEPH'S
UNITY HEALTH TORONTO

MOHS MICROGRAPHIC SURGERY

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PATIENT DEMOGRAPHICS

Patient's name:	Date of Birth:
Address:	
OHIP number with VC:	Home phone no.:
Patient's email address:	Cell phone no.:
Alternate contact for booking (i.e. family member):	

REFERRAL INFORMATION

Diagnosis	BCC ☐ SCC ☐
Site	Right ☐ Left ☐ Midline ☐ : _____
Tumour dimensions	

Has a biopsy been done? Yes ☐ No ☐ If yes, please attach

Biopsy site photo taken on patient's phone? Yes ☐ No ☐

You may optionally submit photos to mohs@stjoestoronto.ca

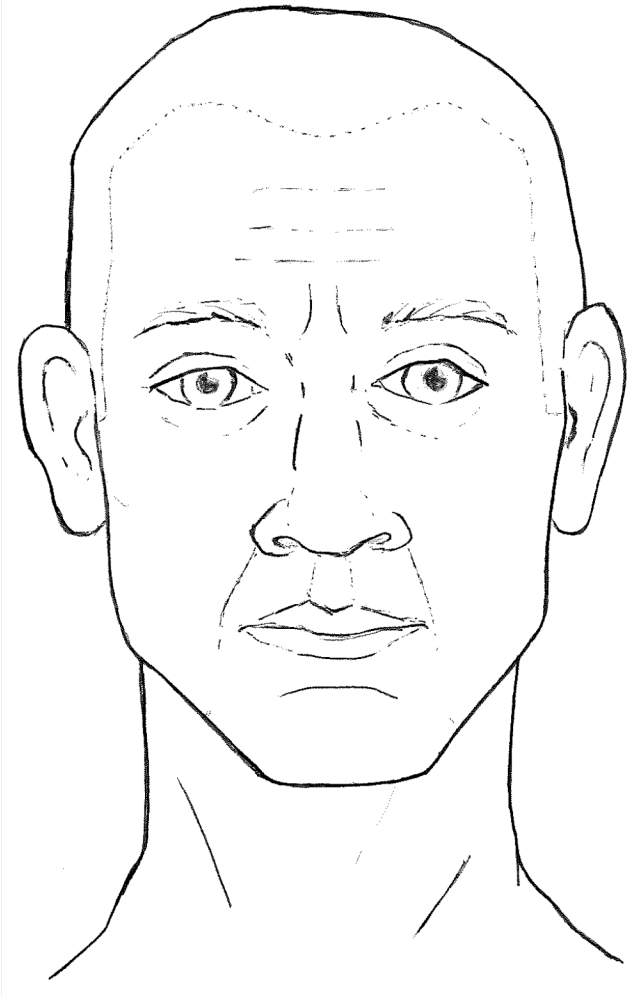
How long has tumour been present? _____

Are you aware of any prior treatments? _____

Does patient have cognitive impairment? Yes ☐ No ☐

Does patient need assistance getting in and out of chair? Yes ☐ No ☐

Any additional history you would like to provide?



Please mark the exact site of the tumour on this diagram

REFERRING PHYSICIAN INFORMATION

Referring Physician:	Billing number:
Address:	
Telephone number:	Fax number