



P000132

MOHS MICROGRAPHIC SURGERY CLINIC

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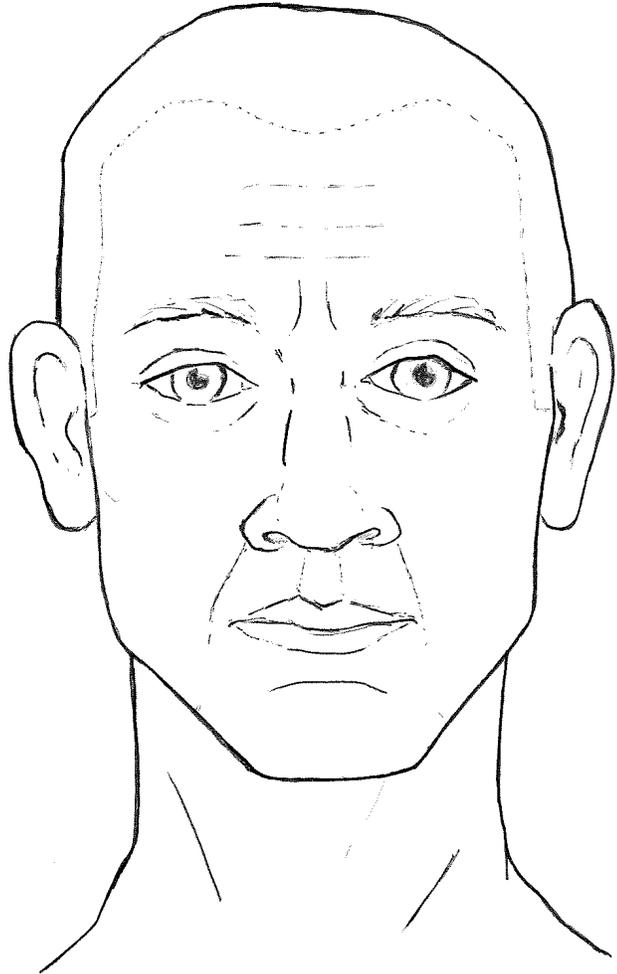
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PATIENT DEMOGRAPHICS

Patient's name:		Date of Birth:
Address:		
OHIP number with VC:		Home phone no.:
Patient's email address:		Cell phone no.:

REFERRAL INFORMATION

Diagnosis	BCC <input type="checkbox"/>	SCC <input type="checkbox"/>
Site	Right <input type="checkbox"/> Left <input type="checkbox"/> Midline <input type="checkbox"/> : _____	
Tumour dimensions	_____	
Has a biopsy been done? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please attach. If no, please note that your patient will be booked for consultation and biopsy prior to surgery.		
Was a biopsy site selfie photo done using the patient's phone? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes – on what date? _____		
Is your patient on anticoagulation therapy? yes <input type="checkbox"/> no <input type="checkbox"/> unsure <input type="checkbox"/>		
If yes - Warfarin <input type="checkbox"/> ASA/clopidogrel <input type="checkbox"/> apixiban/NOAC <input type="checkbox"/>		
Does the patient have a pacemaker or ICD? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Any additional history you would like to provide? _____ _____ _____ _____ _____ _____ _____ _____ _____		



Please mark the exact site of the tumour on this diagram

REFERRING PHYSICIAN INFORMATION

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