ST
JOSEPH'S
HEALTH CENTRE TORONTO

P000132

MOHS MICROGRAPHIC SURGERY CLINIC

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

Has a biopsy been done? Yes ☐ No ☐

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?

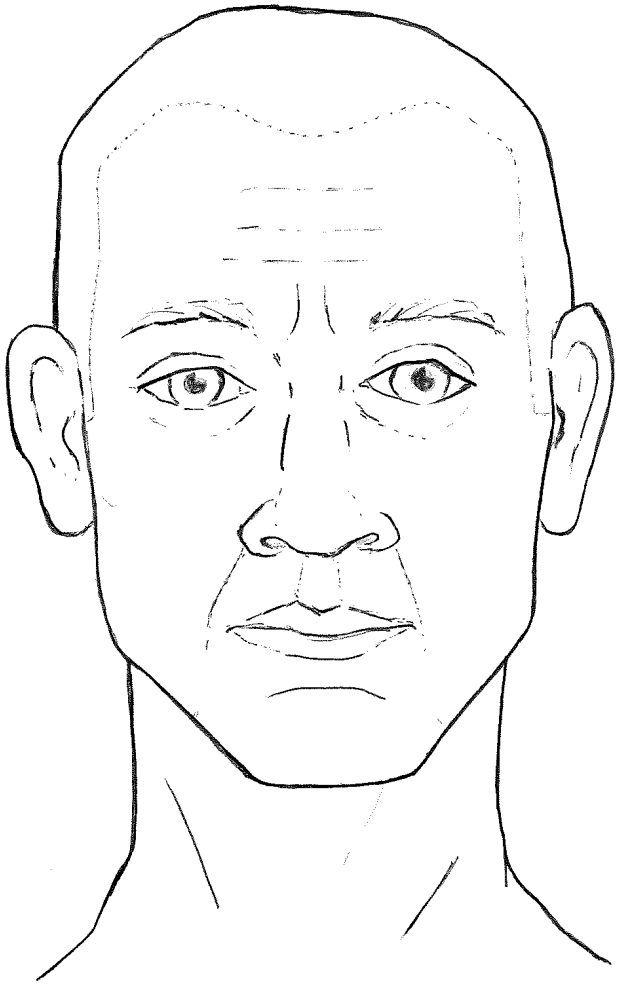
Yes ☐ No ☐ If yes – on what date? _____

Is your patient on anticoagulation therapy? yes ☐ no ☐ unsure ☐

If yes - Warfarin ☐ ASA/clopidogrel ☐ apixiban/NOAC ☐

Does the patient have a pacemaker or ICD? 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:	Signature:	Billing number:
Address:		
Telephone number:	Fax number	