The Ottawa Hospital | L'Hôpital d'Ottawa

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☎ 613-798-5555 ext-poste 19711
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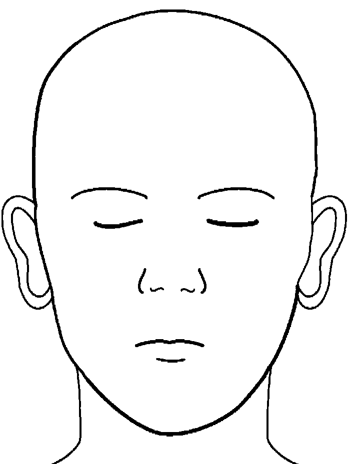
MOHS CLINIC REFERRAL
DEMANDE DE CONSULTATION DE LA CLINIQUE MOHS

Referring physician-Médecin traitant	Date (Clinic visit-Visite à la clinique) (yyaa/mm/dj) :

PATIENT INFORMATION-RENSEIGNEMENTS DU PATIENT

Patient Name	DOB	OHIP #	Version Code
Address	Tel (h)	(w)	(c)



Diagnosis: ❑ BCC ❑ SCC ❑ Other: ______________________

Site: ❑ Right ❑ Left ❑ Midline : ______________________

Tumor Dimensions: ______________________

Please indicate distribution and dimensions on the diagram if on the face

- attach representative photos if available

Has a biopsy been performed? ❑ Yes ❑ No

If yes, please attach a copy of the pathology report

MEDICAL HISTORY

Allergies: ______________________

The patient requires antibiotics before: ❑ Surgical procedures ❑ Dental procedures

The patient takes: ❑ ASA ❑ NSAIDs ❑ Warfarin ❑ Plavix

❑ Other blood thinner, specify: ______________________

The patient has a: ❑ Pacemaker ❑ Implantable Cardioverter Defibrillator (ICD)

Additional history/notes: ______________________

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REPAIRS

❑ MOHS Clinic ❑ Other Physician ______________ ☎ ______________ ✆ ______________

REFERRINGPHYSICIAN

Physician printed name	Signature	Address
Billing Number	☎	✆

PLEASE FAX ALL CORRESPONDENCE TO: ✆ 613-761-4194

CLN 84 (06/2009)