



MOHS CLINIC REFERRAL DEMANDE DE CONSULTATION DE LA CLINIQUE MOHS

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

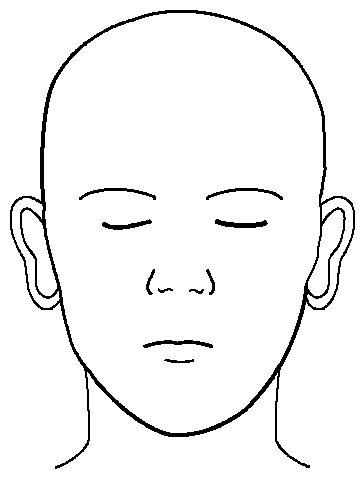
Patient Name	DOB	OHIP #	Version Code
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Address	Tel (h) (w) (c)
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Diagnosis: BCC SCC Other: _____
 Site: Right Left Midline : _____
 Tumor Dimensions: _____

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



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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: _____

REPAIRS

MOHS Clinic Other Physician _____ ☎ _____ 📍 _____

REFERRING PHYSICIAN

Physician printed name	Signature	Address
_____	_____	_____
Billing Number	☎	📍
_____	_____	_____

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