



18127

MOHS CLINIC REFERRAL**Telephone: 613-544-3400 Ext. 23415**

Date of Referral:(yyyy/mm/dd)

PATIENT INFORMATION

Patient Name:

Date of Birth:

yyyy/mm/dd

OHIP Number:

Version Code:

Address:

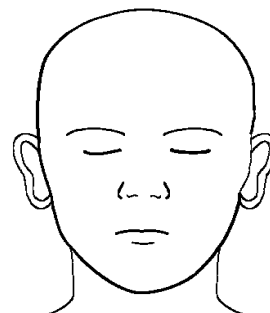
Telephone: (Home) _____

(Work)

(Cell)

Diagnosis: ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma Other: _____Site: ☐ Right ☐ Left ☐ Midline: _____

Tumor Dimensions: _____

*Please indicate distribution and dimensions on the diagram of the face**- Attach representative photos if applicable***NOTE: Copy of the pathology report with definitive cancer diagnosis
required prior to referral.****MEDICAL HISTORY**

Adverse Reactions: _____

The patient requires antibiotics before: ☐ Surgical Procedures ☐ Dental ProceduresThe patient takes: ☐ ASA ☐ NSAIDs ☐ Warfarin ☐ Plavix ☐ Other blood thinner, specify: _____The patient has a: ☐ Pacemaker ☐ Cardiac Implantable Electronic Device (CIED)

Additional history/notes: _____

REFERRING PHYSICIAN_____
Physician printed name_____
Signature_____
Address_____
Billing Number_____
Telephone_____
Fax**PLEASE FAX ALL CORRESPONDENCE TO: FAX NUMBER 613-545-2202**