Skin Surgery Centre
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WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Referral for Skin Surgery Centre

Patient Name: _____ Date of Birth: _____
Address: _____
_____
Patient's Telephone number: _____(h) _____(b)
Patient's Email Address:_____
OHIP#: _____ Version Code: _____

Referred for: Consultation ☐ **OR** Consultation and Mohs surgery on the same day ☐

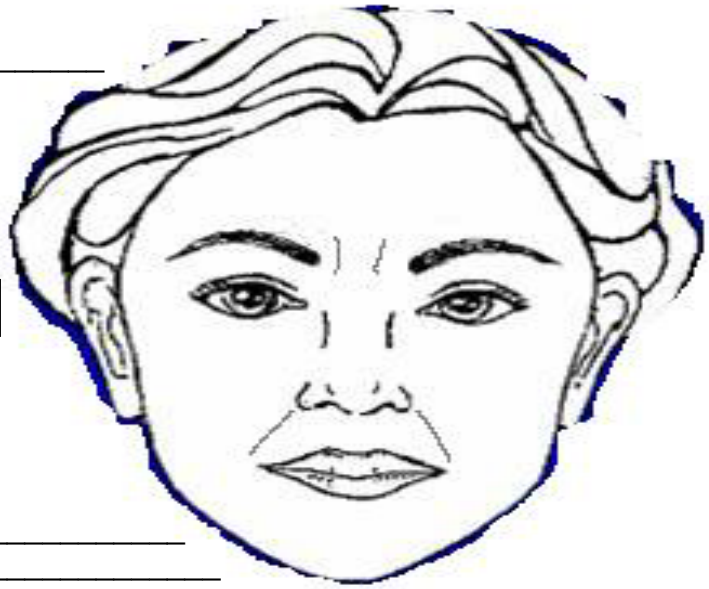
Note: For *consultation on the day of Mohs surgery we require both:*
1) a pathology report *documenting non-melanoma skin cancer* ***and***
2) a representative photograph(s) which can be emailed to mohs@wchospital.ca or accurate diagram *identifying the exact location and size of the tumour to allow adequate pre-operative planning*

Referral information:

Diagnosis: BCC ☐, SCC ☐, Other tumour ☐ _____

Site: right ☐, left ☐, midline ☐ **:** _____

(and indicate on diagram if on the face)



Has a biopsy been done?: Yes ☐ No ☐
(If yes, please attach a copy of the pathology report)

Stitches to be removed at Mohs?: Yes ☐ No ☐

Roughly what are the dimensions of the tumour?

_____

Any additional history you wish to provide:

_____
_____
_____
_____
_____
_____

Referring Physician Information:
Physician Name: _____ Billing Number: _____
Address: _____
Telephone Number: _____ **Fax:** _____
Referring Physician Signature:_____