WCH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2
Tel: 416-323-7732 Fax: 416-323-6306

MOHS SURGERY CENTRE REFERRAL FORM

URGENCY: ❑ Routine ❑ Semi-Urgent ❑ Urgent

REFERRAL DATE: ____/____/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____

Name:_____

Sex:_____ Date of Birth:____/____/_____
DD / MM / YYYY

Address:_____

Telephone:_____ Alternate #:_____

SPECIFIC PHYSICIAN: ☐ First Available OR ☐ Dr. Christian Murray ☐ Dr. Nowell Solish ☐ Dr. An-Wen Chan

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ _____

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: _____

Signature: _____

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: _____ Phone:_____ Fax:_____

REASON FOR REFERRAL

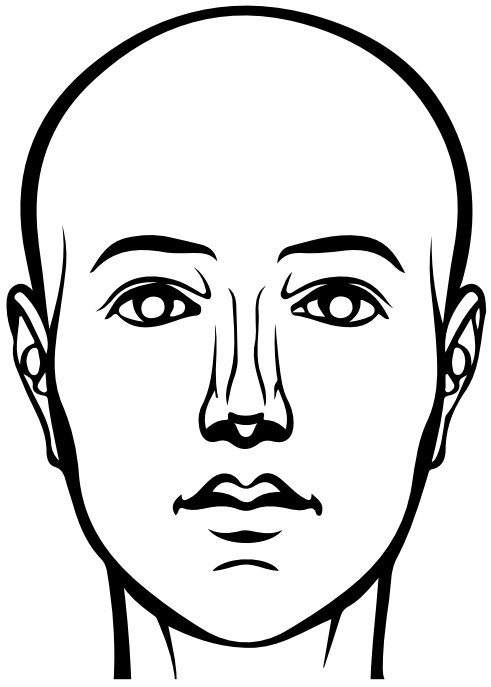
Diagnosis:
☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma
☐ Other tumor:

Tumor site: (*please also indicate site on face diagram if applicable*)
Location (e.g. chin):_____
☐ Right ☐ Left ☐ Midline

Tumor size estimate in mm: _____ x _____

Biopsy done:
☐ No ☐ Yes (*please attach pathology report*)

Photograph:
☐ No (*indicate shape/size on the face diagram*)
☐ Yes (*please email to mohs@wchospital.ca*)



ADDITIONAL CLINICAL INFORMATION

Allergies and reaction:

Current medications (include list):

Additional Information Relevant to Procedure:
Patient is ambulatory and can get in/out of chair: ☐ Yes ☐ No
Does patient have dementia: ☐ Yes ☐ No
Other relevant information: _____
_____
_____