



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street  
Toronto, Ontario  
Healthcare | REVOLUTIONIZED 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

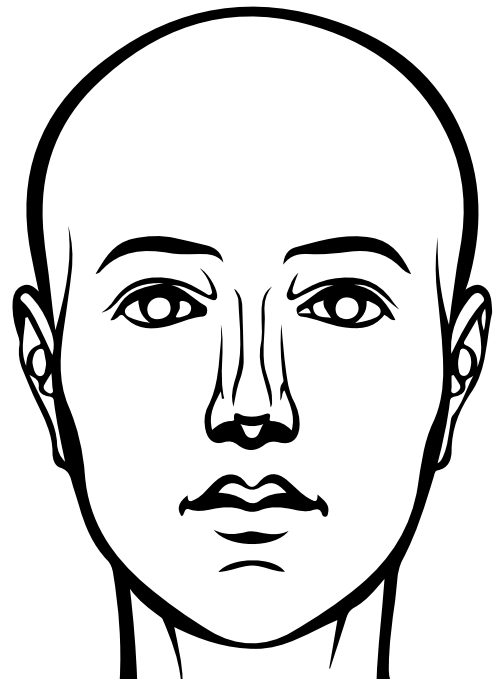
Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Billing #: \_\_\_\_\_  
Signature: \_\_\_\_\_  
☐ Referring Provider is not the Primary Care Provider  
Primary Care Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### 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](mailto: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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Fax Disclaimer: This fax transmission contains confidential information that is intended only for the Women's College Hospital Clinics. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the referring health practitioner at the telephone number provided above to arrange for the return or destruction of this document.

