

Dr. Erin Dahlke, Dr. Christian Murray,
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 Dr. Roxana Mititelu, Dr. Michael Weinberg,
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Referral for Skin Surgery

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

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

Diagnosis: BCC SCC Other tumour _____

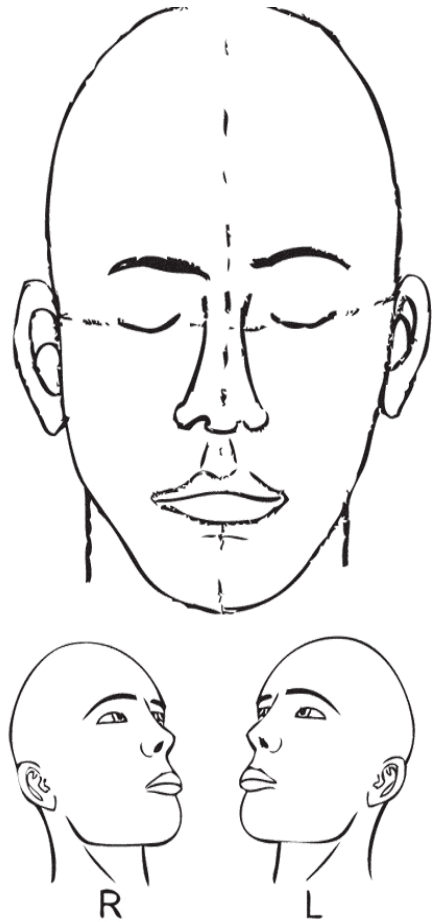
Site?: right, left, midline : _____
 (and indicate on diagram, or draw)

Size of the tumour in mm x mm? _____

Has a biopsy been done?
 Yes --> please attach the report
 No -> we might need to do first

Any additional history? (circle if relevant please)

- | | |
|-------------------------|-----------|
| Previous treatments: | Yes or No |
| On ASA? | Yes |
| On warfarin? | Yes |
| On other blood thinner? | Yes |
| Past closeby radiation? | Yes |
| Anxious person? | Yes |
| Has a pacemaker? | Yes |
| Very limited mobility? | Yes |



Photos? Please have the patient bring a photo of the biopsy site and/or lesion to their appointment. The photo should show the site and can be on a phone.

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

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