Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston
HOTEL DIEU HOSPITAL

MOHS CLINIC REFERRAL

Telephone: 613-544-3400 Ext. 3415

Date of Referral:(yyyy/mm/dd)

PATIENT INFORMATION

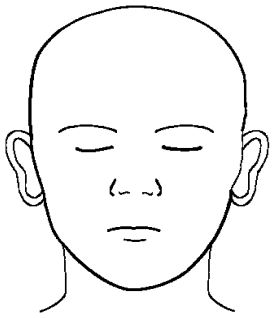
Patient Name:	Date of Birth: yyyy/mm/dd	OHIP Number: Version Code:
Address:	Telephone: (Home) _____ (Work) (Cell)	

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 Procedures

The 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