Mohs Micrographic Surgery Referral Form

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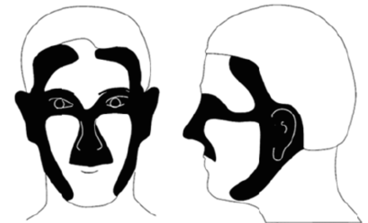
REFERRAL CRITERIA

Mohs Micrographic Surgery (MMS) Indications

Mohs micrographic surgery is recommended for patients with complex skin cancers that are best managed with intra-operative margin control to provide the highest cure rate and minimize normal tissue resection. In an effort to ensure effective triaging of patients in need of this specialized technique we adhere to the established appropriate use criteria for MMS. Please indicate which criteria your patient has on the list below.

Please CHECK one or more and provide details when required.

- There is a biopsy report showing BCC or SCC or other skin cancer (please circle the type or write in the name on the line): ____
- Recurrent or incompletely excised tumours. Treated before with (circle all that apply) excision, ED+C, cryotherapy, topical chemo/immunotherapy to treat skin cancer, PDT, radiation
- Primary tumours of the face > than 1 cm or < 1 cm in H zone of face (see adjacent picture)
- Ill-defined clinical borders
- Adjacent/involving the (circle all that apply): eyelid, peri-ocular, nose, cutaneous lip, lip vermilion, ear, pre or post auricular, temple, jawline, medial cheek next to the nose, the “H-zone of the face” (please see the diagram)



- Patients with a history of (circle all that apply): immunosuppression, organ transplant recipient, Gorlin’s syndrome, other genetic disorder condition with a predisposition for skin cancer formation,
- Aggressive histology such as (circle all that apply): Basosquamous, morpheaform/sclerosing, infiltrating, micronodular, perineural invasion, poor differentiation
- Previous irradiation of the location where the tumour is located

Please indicate on the image below the location of the tumour:

Site	**Right ( ) Left( ) Midline( ):** ______________________

Tumour dimensions:

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PATIENT DEMOGRAPHICS

Patient's name:	Date of Birth:	
Address:		
MSI number:	Home phone no.:	Cell phone no.:
Patient's email address:		

REFERRAL INFORMATION

If possible, please email a photo of the biopsy site to admin@precisiondermatology.ca or take a picture on the patient's phone.

Was a biopsy site photograph emailed? Yes ( ) No ( )
Was a biopsy site photo taken using the patient's phone? Yes ( ) No ( ) If so – on what date?

Is the patient taking blood thinners yes ( ) no ( ) unsure ( )
If yes - Warfarin ( ) ASA/clopidogrel ( ) apixaban/Direct oral anticoagulant ( )

Does the patient have a pacemaker or ICD yes ( ) no ( )

Any additional history you would like to provide (e.g., duration)?

REFERRING PHYSICIAN INFORMATION

Referring Physician:	Signature:	Billing number:
Date of Referral:		
Address:		
Telephone number:	Fax number:	
Family Physician:		