Akron Dermatology
Mohs Micrographic Surgery Referral/Consultation Checklist
Alexandra Zhang, MD
Utilizing this form can help us offer your patient more effective care.
Please fax this completed form and copy of pathology report to 330-535-2600

Patient Name: _____ **Date of Birth: _____**
Patient Phone #: _____

Referring Physician: _____
Referring Physician Phone #: _____ **Referring Physician Fax #: _____**

Tumor Type (check): **Tumor Location: _____**

Basal Cell Carcinoma (BCC) ☐

Tumor Size: _____ cm

Squamous Cell Carcinoma ☐
Other: _____

Pathology Report Attached:	**Yes ____**	**No ____**
Photo Available:	**Yes ____**	**No ____**
Diagram Available:	**Yes ____**	**No ____**

Patient Medical History (please check yes or no):

Pacemaker/Defibrillator:	**Yes ____**	**No ____**
Heart Valve Problems:	**Yes ____**	**No ____**
Artificial Joint:	**Yes ____**	**No ____**
Prophylactic Antibiotics for dental/medical procedures:	**Yes ____**	**No ____**
Bleeding Problems:	**Yes ____**	**No ____**
Hypertension:	**Yes ____**	**No ____**
Organ Transplant:	**Yes ____**	**No ____**
Immunocompromised/Currently taking any immunosuppressants?	**Yes ____**	**No ____**
Insulin Dependent Diabetes:	**Yes ____**	**No ____**

Anticoagulation (please check all that apply):

Coumadin ____
Plavix ____
ASA ____
Lovenox ____
Pradexa ____
NSAIDS ____

Additional Comments:

_____
_____
_____

Akron Dermatology
566 White Pond Dr.
Akron, OH 44320
Phone: 330-535-7100/Fax : 330-535-2600
Email: medical@akronderm.com (no patient information in emails please)
www.akronderm.com