

# MOHS MICROGRAPHIC SURGERY

## OPERATION NOTES



**PATIENT NAME**

**HOSPITAL NUMBER**

**DATE OF BIRTH**

DATE:

OPERATOR:

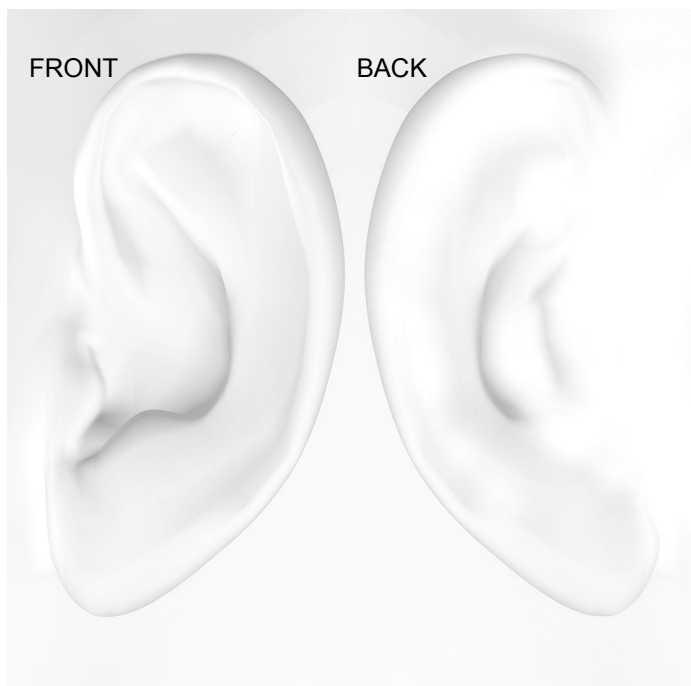
TECHNICIAN:

DIAGNOSIS: REF:

PRIOR Rx:

DRUGS/ALLERGIES/ANTICOAG/PACEMAKER:

INDICATIONS: RECURRENT:  INFILTRATIVE:  YOUTH:  SIZE:  INDISTINCT:  SITE:



PRE-OP SIZE:

PHOTO: Y N

Mohs Layer	Sections	+	Anaesthetic (ml)
1			
2			
3			
4			
5			
			TOTAL:

Red  
Blue  
Green  
Yellow

POST-OP SIZE:

PHOTO: Y N

REPAIR:



PHOTO: Y N

WOUND CARE:

FOLLOWUP: