

MOHS MICROGRAPHIC SURGERY

OPERATION NOTES



PATIENT NAME

HOSPITAL NUMBER

DATE OF BIRTH

DATE:

OPERATOR:

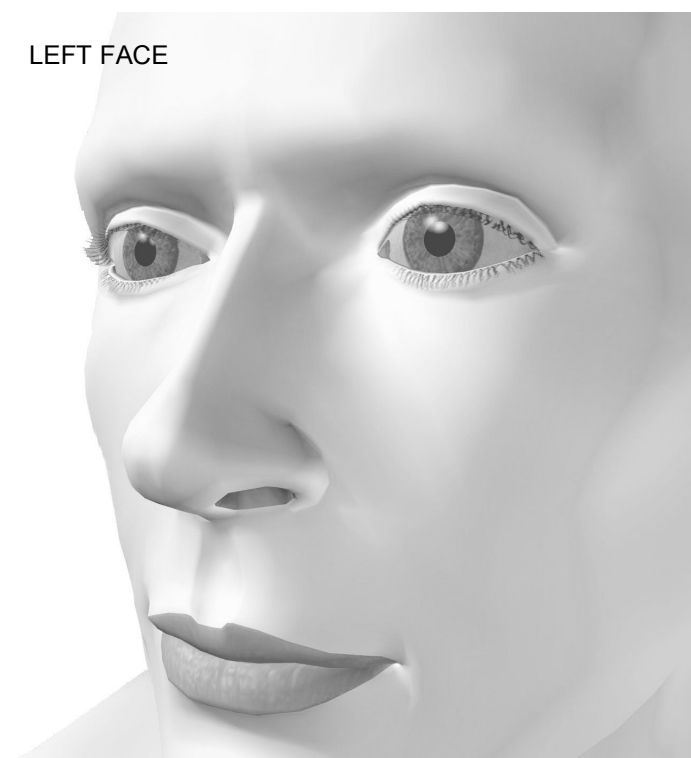
TECHNICIAN:

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: