

MOHS MICROGRAPHIC SURGERY

OPERATION NOTES



PATIENT NAME HOSPITAL NUMBER DATE OF BIRTH	DATE: <hr/> OPERATOR: <hr/> TECHNICIAN: <hr/> DIAGNOSIS: REF: <hr/> PRIOR Rx: <hr/> DRUGS/ALLERGIES/ANTICOAG/PACEMAKER: <hr/>
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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: