1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Harold J. Lindqvist

DOB
01/22/1952

AGE/SEX
74 / Male

MRN / PATIENT ID
HJL-4410286

DATE OF SERVICE
10/07/2026

PROVIDER
Samuel Okafor

CREDENTIALS
MD, FACMS

VISIT TYPE
Mohs Procedure Visit (same-day reconstruction)

CARE SETTING
Outpatient — Mohs Surgery Clinic

PRIMARY DERMATOLOGIST, IF APPLICABLE
Laura Chen, MD

PRIMARY CARE PROVIDER, IF APPLICABLE
Gregory Pratt, MD

REFERRING PROVIDER, IF APPLICABLE
Laura Chen, MD

INTERPRETER USED, IF APPLICABLE
Not required — English

CHAPERONE PRESENT, IF APPLICABLE
Surgical assistant present throughout

CC CHIEF COMPLAINT

2 PRIMARY MOHS CONCERN

"The skin cancer on my nose came back where they scraped it four years ago. Dr. Chen said this time it needs the layer-by-layer surgery."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a TUMOR & PATHOLOGY HISTORY

Reason for Mohs Surgery Evaluation:

Same-day Mohs surgery for a biopsy-proven recurrent basal cell carcinoma with aggressive (infiltrative) histology on the left nasal ala — a high-risk location needing tissue sparing. Reconstruction planned same day.

Lesion / Tumor History:

Left nasal ala; treated with ED&C in 2022. A firm, shiny, scar-like area within the old site appeared ~10 months ago, slowly enlarging, with intermittent crusting and pinpoint bleeding when he blows his nose. Mildly tender. Worried about "losing part of my nose."

Biopsy / Pathology History:

Shave biopsy 08/28/2026 (Dr. Chen): basal cell carcinoma, infiltrative and nodular subtypes, extending to the deep and peripheral margins of the specimen; no perineural invasion identified. Pathology report reviewed; slides reviewed by Mohs surgeon today.

Skin Cancer History:

Five prior BCCs (back ×2, R temple, L nasal ala 2022, R ear); one SCC in situ of the R dorsal hand (excised 2019). Numerous actinic keratoses; 5-FU field therapy to the scalp 2023. One prior Mohs (R ear helix, 2024). No melanoma, no radiation.

High-Risk Tumor Features:

H-zone (nasal ala); recurrent; infiltrative histology; poorly defined borders within scar; size 1.1 × 0.9 cm clinically. Not immunosuppressed, no prior radiation. Denies numbness or paresthesia. Close to the alar rim and nostril — functional and cosmetic concern.

Surgical Site Symptoms:

Intermittent crusting and pinpoint bleeding; mild tenderness. No drainage, numbness, nasal obstruction, or infection signs.

3b SURGICAL RISK REVIEW

Medication and Anticoagulation History:

Apixaban 5 mg BID (atrial fibrillation) — continued per cardiology; last dose 07:00 today. Aspirin stopped in 2025. Metformin 1000 mg BID, lisinopril 20 mg, atorvastatin 40 mg, tamsulosin. Fish oil stopped 7 days ago at our request. No immunosuppressants.

Medical Risk Factors:

Type 2 diabetes (A1c 7.2%), hypertension, permanent atrial fibrillation, dual-chamber pacemaker (2021, for sick sinus syndrome). Left total knee arthroplasty 2018. CKD stage 3a (eGFR 54). Former smoker, 30 pack-years, quit 2005. No keloids or prior wound complications.

Allergy History:

Penicillin (hives). No reactions to lidocaine with epinephrine at prior Mohs. No latex or adhesive allergy.

Infection / Prophylaxis Considerations:

No prosthetic valve or prior endocarditis. Pacemaker and knee arthroplasty >2 years old — prophylaxis not indicated for clean cutaneous surgery per AAD/AAOS guidance. Diabetes noted. No MRSA history.

Functional and Cosmetic Concerns:

Wants to keep nostril shape and breathing. Cares for his wife (early dementia) — needs a simple wound-care routine; daughter can help for 1 week.

Reconstruction History and Preferences:

Ear defect in 2024 healed by second intention — happy with result. Open to a flap or graft on the nose; prefers single-stage repair today if possible.

Post-Operative Symptoms, if applicable:

Not applicable — pre-operative.

3c PREVENTION & BACKGROUND

Sun Exposure and Prevention History:

Retired wheat farmer (50 years outdoors). Many sunburns. Wears a cap but rarely sunscreen. Never used tanning beds. Dermatology visits every 6 months.

Family History:

Brother — multiple BCCs. No melanoma or known syndromes.

Social / Occupational History:

Lives with wife on a farm 40 miles away; daughter drove him today and will stay for 1 week. Able to do wound care with assistance. Alcohol: rare.

Pertinent Negatives:

Denies rapid growth, numbness, facial weakness, fever, chest pain, dyspnea, or syncope. No prior uncontrolled bleeding on apixaban.

ROS MOHS SURGERY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

New, changing, bleeding, painful, crusting, ulcerated, or non-healing skin lesion
Positive — enlarging, crusting, bleeding L nasal ala lesion.

Surgical site pain, tenderness, drainage, bleeding, swelling, redness, or wound separation
Mild tenderness only.

Numbness, tingling, weakness, facial movement changes, or functional impairment near tumor site
Negative.

Fever, chills, infection symptoms, or systemic symptoms
Negative.

Easy bruising, bleeding tendency, anticoagulant use, or prior surgical bleeding complications
Positive — on apixaban; bruises easily. No prior surgical bleeding.

Poor wound healing, keloid tendency, diabetes-related healing concerns, or immunosuppression
Diabetes (controlled). No keloids or immunosuppression.

Anxiety, cosmetic concern, functional concern, or distress related to skin cancer or surgery
Mild anxiety about nose appearance; reassured.

O OBJECTIVE

5 OBSERVED FINDINGS

5a VITALS, IF OBTAINED

TEMPERATURE	BLOOD PRESSURE	HEART RATE
97.9 °F	142/80	70 (paced)
RESPIRATORY RATE	**OXYGEN SATURATION**	**HEIGHT**
16	97% RA	5′11″
WEIGHT	**BMI**	**PAIN SCORE, IF APPLICABLE**
196 lb	27.3	1/10

5b EXAMINATION

General Appearance:

Alert, cooperative, mildly anxious; able to lie supine for prolonged periods. Good overall condition.

Tumor / Lesion Examination:

L nasal ala: 1.1 × 0.9 cm pearly, indurated, ill-defined plaque within a hypopigmented atrophic scar, with central 3 mm crust and telangiectasias. Healing biopsy site at the center. Not fixed to cartilage on palpation. Lesion edge 3 mm from the alar rim; spares the alar groove. Background severe actinic damage.

Anatomic Site Assessment:

Nasal ala (H-zone) within prior ED&C scar; close to the free alar margin and external nasal valve. No prior radiation.

Regional Lymph Node Examination, if relevant:

No preauricular, submandibular, or cervical lymphadenopathy.

Neurologic / Functional Assessment, if relevant:

Facial nerve intact; sensation normal over the nose. Nasal airflow symmetric at baseline; no valve collapse on deep inspiration.

Surgical Site / Wound Examination, if post-operative:

Not applicable — pre-operative.

Full or Focused Skin Examination, if performed:

Focused head and neck: ~12 actinic keratoses (scalp, dorsal nose, ears); healed scars at R ear and R temple with no recurrence. Rest deferred to Dr. Chen.

PT PATHOLOGY / TUMOR ASSESSMENT

6 PATHOLOGY FOR SURGICAL PLANNING

DIAGNOSIS
Basal cell carcinoma

HISTOLOGIC SUBTYPE
Infiltrative with nodular component

BIOPSY SITE AND DATE
L nasal ala — 08/28/2026

TUMOR SIZE CLINICALLY AND PATHOLOGICALLY IF AVAILABLE
1.1 × 0.9 cm clinically; transected on biopsy

DEPTH OR LEVEL OF INVASION IF AVAILABLE
Reticular dermis (base transected)

DIFFERENTIATION FOR SQUAMOUS CELL CARCINOMA IF AVAILABLE
N/A (BCC)

PERINEURAL INVASION IF REPORTED
None identified

LYMPHOVASCULAR INVASION IF REPORTED
None identified

MARGINS IF AVAILABLE
Positive deep and peripheral

RECURRENT VERSUS PRIMARY TUMOR
Recurrent (prior ED&C 2022)

PRIOR TREATMENT STATUS
ED&C 2022

PATHOLOGY REPORT OR SLIDES REVIEWED
Both reviewed by Mohs surgeon

NEED FOR SLIDE CONSULTATION OR DERMATOPATHOLOGY REVIEW
Not needed — concordant

MA MOHS APPROPRIATENESS / RISK ASSESSMENT

7 RATIONALE FOR MOHS

TUMOR TYPE
BCC

TUMOR LOCATION
H-zone (nasal ala)

TUMOR SIZE
1.1 cm

RECURRENT TUMOR STATUS
Recurrent

AGGRESSIVE HISTOLOGY
Infiltrative

POORLY DEFINED BORDERS
Yes — within scar

TISSUE-SPARING NEED
High — alar rim and nasal valve

IMMUNOSUPPRESSION OR HIGH-RISK HOST FACTORS
None

PRIOR RADIATION OR SCAR SITE
Prior ED&C scar

FUNCTIONAL OR COSMETIC IMPORTANCE OF SITE
High

ALTERNATIVE TREATMENTS DISCUSSED
Wide local excision with frozen sections; radiation therapy; observation (declined)

PATIENT PREFERENCE AND SHARED DECISION-MAKING
Chose Mohs; AUC score 9 (appropriate)

MP PROCEDURE PERFORMED: MOHS MICROGRAPHIC SURGERY, IF APPLICABLE

8 MOHS PROCEDURE DETAILS

PRE-OPERATIVE DIAGNOSIS
Recurrent infiltrative BCC, L nasal ala

INDICATION FOR MOHS SURGERY
Recurrent, aggressive histology, H-zone

ANATOMIC LOCATION
Left nasal ala

PRE-OPERATIVE LESION SIZE
1.1 × 0.9 cm

CONSENT OBTAINED
Written, after risks/benefits/alternatives

TIMEOUT / SITE VERIFICATION
Completed; site confirmed by patient and biopsy photo

LOCAL ANESTHESIA USED
1% lidocaine with 1:100,000 epinephrine, 4 mL total (incl. repair)

SKIN PREPARATION
Chlorhexidine (eyes protected)

DEBULKING IF PERFORMED
Curettage debulk; sent for permanent sections

NUMBER OF MOHS STAGES
2

TISSUE BLOCKS PER STAGE
Stage 1: 4 blocks; Stage 2: 2 blocks

HISTOLOGIC FINDINGS PER STAGE
Stage 1: infiltrative BCC at 2–4 o'clock deep/peripheral; Stage 2: clear

MARGINS CLEARED OR RESIDUAL TUMOR STATUS
Clear after Stage 2

FINAL DEFECT SIZE
1.8 × 1.5 cm, to perichondrium of lateral crus

HEMOSTASIS METHOD

PATIENT TOLERANCE

HEMOSTASIS METHOD

Bipolar electrocautery (pacemaker — bipolar only, brief bursts)

PATIENT TOLERANCE

Excellent

COMPLICATIONS IF ANY

None

POST-OPERATIVE DIAGNOSIS

BCC, infiltrative, L nasal ala — clear margins

WOUND MANAGEMENT / RECONSTRUCTION PLAN

Bilobed transposition flap, same day

SPECIMEN HANDLING AND MAP DOCUMENTATION

Color-coded map, en face frozen sections, H&E

MS MOHS STAGE DOCUMENTATION, IF APPLICABLE

9 STAGE-BY-STAGE FINDINGS

Stage 1:

4 blocks. Tumor present — infiltrative strands of BCC at the deep and peripheral margins of block 2 (2–4 o'clock, inferolateral toward the alar rim). Blocks 1, 3, 4 clear. Mapped and marked.

Stage 2:

2 blocks, taken only from the 2–4 o'clock region with 2 mm added margin, sparing alar rim cartilage. Tumor absent. Map correlates.

Additional Stages:

None required.

Final Stage:

Complete margin clearance after Stage 2. Final defect 1.8 × 1.5 cm on the L nasal ala, 3 mm from the alar rim, depth to perichondrium.

RR RECONSTRUCTION / REPAIR DOCUMENTATION, IF APPLICABLE

10 REPAIR DETAILS

RECONSTRUCTION TYPE

Flap — bilobed transposition flap (Zitelli), inferiorly based

INDICATION FOR SELECTED REPAIR

Preserve alar rim and avoid notching; single-stage tissue match

FINAL DEFECT SIZE

1.8 × 1.5 cm

UNDERMINING PERFORMED

Submuscular (nasalis) undermining over the nasal sidewall and dorsum

DEEP AND SUPERFICIAL SUTURE MATERIALS

5-0 Monocryl deep; 6-0 Prolene and 6-0 fast-absorbing gut superficial

CLOSURE LENGTH

Total repair 5.2 cm

FLAP OR GRAFT TYPE AND DIMENSIONS

Primary lobe 1.8 cm, secondary lobe 1.5 cm, 100° arc

DONOR SITE IF APPLICABLE

Nasal sidewall and dorsum, closed primarily

HEMOSTASIS

Bipolar cautery

DRESSING APPLIED

Petrolatum, nonstick pad, paper-tape pressure dressing

PATIENT TOLERANCE

Excellent

COMPLICATIONS IF ANY

None

FUNCTIONAL/COSMETIC OUTCOME IMMEDIATELY AFTER REPAIR

Alar rim symmetric, no notching; nasal valve patent

WOUND CARE INSTRUCTIONS

Pressure dressing 48 h, then daily cleaning + petrolatum

FOLLOW-UP PLAN

Suture removal 1 week; scar check 3 months

OP OTHER PROCEDURES PERFORMED, IF APPLICABLE

11 ADDITIONAL DERMATOLOGIC SURGERY

Debulking specimen: curettage debulk of the tumor before Stage 1, sent for permanent sections to confirm subtype (results in 5–7 days). Cryotherapy: liquid nitrogen to 6 actinic keratoses on the scalp and ears (two 10-second freeze-thaw cycles each), verbal consent; tolerated well. Aftercare handout given.

PO POST-OPERATIVE / WOUND ASSESSMENT, IF APPLICABLE

12 WOUND HEALING STATUS

SURGERY DATE AND PROCEDURE PERFORMED

10/07/2026 — Mohs + bilobed flap

REPAIR TYPE

Bilobed transposition flap

PAIN LEVEL AND ANALGESIC USE

1/10 at discharge; acetaminophen only (no NSAIDs, on apixaban)

BLEEDING, DRAINAGE, SWELLING, BRUISING, OR INFECTION SYMPTOMS

None at discharge

WOUND CARE ADHERENCE

Taught to daughter; teach-back done

ACTIVITY RESTRICTION ADHERENCE

To be assessed at suture removal

INCISION APPROXIMATION

Well approximated

FLAP/GRAFT VIABILITY

Pink, good capillary refill

SUTURE/STAPLE STATUS

In place

DEHISCENCE, NECROSIS, HEMATOMA, SEROMA, OR INFECTION SIGNS

None

SCAR MATURATION AND PATIENT CONCERNS

Expected 6–12 months

NEED FOR SUTURE REMOVAL, WOUND CARE CHANGE, CULTURE, ANTIBIOTICS, REVISION, OR ADDITIONAL FOLLOW-UP

NEED FOR SUTURE REMOVAL, WOUND CARE CHANGE, CULTURE, ANTIBIOTICS, REVISION, OR ADDITIONAL FOLLOW-UP

Suture removal 10/14; possible dermabrasion at 8 weeks if needed

L LABORATORY AND DIAGNOSTIC RESULTS

13 REVIEWED & ORDERED

Dermatopathology:

Biopsy 08/28: infiltrative + nodular BCC, margins positive, no PNI. Mohs frozen sections: Stage 1 positive (2–4 o'clock), Stage 2 clear. Debulk permanent sections pending.

Imaging:

Not indicated — no perineural symptoms or deep invasion.

Microbiology:

None.

Medication / Safety Labs:

CBC 09/2026 (PCP): Hgb 13.8, platelets 212. Creatinine 1.3, eGFR 54. A1c 7.2%. INR not needed (apixaban).

Prior Records Reviewed:

Dr. Chen's notes and biopsy photo; 2022 ED&C record; 2024 Mohs report (R ear); cardiology note 09/2026 (continue apixaban; pacemaker settings — bipolar cautery acceptable, no reprogramming needed).

A ASSESSMENT

14 MOHS CLINICAL INTERPRETATION

1) Recurrent basal cell carcinoma, infiltrative subtype, L nasal ala, 1.1 cm — high-risk by location, recurrence, and histology; Mohs appropriate (AUC 9). Cleared in 2 stages; final defect 1.8 × 1.5 cm. Clinical and frozen-section pathology concordant. 2) Repaired with a bilobed transposition flap that preserves the alar rim and nasal valve; flap viable at discharge. 3) Surgical risks: continued apixaban (higher bleeding/hematoma risk, managed with careful bipolar hemostasis and pressure dressing); pacemaker (bipolar cautery only); diabetes and former smoking (flap healing). No antibiotic prophylaxis indicated. 4) Multiple actinic keratoses — treated with cryotherapy. Patient and daughter understand the plan and expected scar.

P PLAN

15 MOHS MANAGEMENT BY PROBLEM & STAGE

Mohs surgery plan

Completed today — 2 stages, clear margins.

Reconstruction plan

Bilobed flap completed. Expect swelling and a "trapdoor" look for 6–8 weeks; possible intralesional triamcinolone or spot dermabrasion at 8–12 weeks if needed.

Medication management plan

Continue apixaban as scheduled (evening dose tonight). Acetaminophen 1 g q8h PRN (max 3 g/day); avoid NSAIDs. Stay off fish oil until suture removal. No antibiotics (penicillin allergy noted).

Pre-operative plan

Completed: site verified, consent, photos, pacemaker precautions (bipolar cautery), daughter as driver.

Post-operative wound care plan

Keep pressure dressing dry and on 48 h; then clean daily with saline, apply petrolatum and a nonstick bandage. Ice 15 min/h while awake for 48 h. Sleep with head raised on 2 pillows. No bending, heavy lifting (>10 lb), or nose blowing for 1 week; sneeze with mouth open. For bleeding: firm, continuous pressure for 20 min; call if it does not stop.

Follow-up plan

Suture removal 10/14/2026; scar check 3 months.

Skin cancer prevention plan

Broad-spectrum SPF 50 daily, wide-brim hat instead of a cap. Discussed nicotinamide 500 mg BID for chemoprevention given multiple keratinocyte cancers. Continue skin checks every 6 months with Dr. Chen.

High-risk tumor plan

Not indicated beyond close surveillance — clear margins, no PNI.

Complication management plan

24-h on-call number given. Return the same day for expanding swelling (hematoma), dark or dusky flap, fever, pus, or spreading redness. If infected: culture, then doxycycline (penicillin-allergic).

Patient education

Written and verbal instructions given to the patient and daughter; teach-back confirmed.

F FOLLOW-UP

16 REASSESSMENT PLAN

Phone check in 24 h (nurse). Suture removal and flap check on 10/14/2026 — debulk pathology reviewed then. Scar evaluation at 3 months. Ongoing skin surveillance every 6 months with Dr. Chen. Return immediately for bleeding that pressure does not control, or for flap color change.

TB TIME DOCUMENTATION & BILLING

17 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
4 h 10 min (incl. lab processing)

MOHS COUNSELING TIME
15 minutes

PROCEDURE TIME
2 h 30 min (2 stages)

RECONSTRUCTION / REPAIR TIME, IF APPLICABLE
55 minutes

WOUND CARE COUNSELING TIME, IF APPLICABLE
10 minutes

CARE COORDINATION TIME
5 minutes

RECORDS / PATHOLOGY REVIEW TIME, IF APPLICABLE
10 minutes

17a BILLING CONSIDERATIONS — MOHS SURGERY / DERMATOLOGIC SURGERY CODING

MOHS SURGERY CODE(S)

NUMBER OF STAGES

17311, 17312

2

NUMBER OF TISSUE BLOCKS

6 (4 + 2) — no 17315

REPAIR CODE(S), IF APPLICABLE

14060 (adjacent tissue transfer, nose, ≤10 cm²)

BIOPSY / EXCISION CODE(S), IF APPLICABLE

—

WOUND CARE / SUTURE REMOVAL CODE(S), IF APPLICABLE

Suture removal within global period

E/M LEVEL, IF SEPARATELY APPLICABLE

Not billed — decision for surgery made at prior visit

BASIS FOR BILLING

Mohs procedure + reconstruction; 17000/17003 for AK destruction

ICD-10 DIAGNOSIS CODES

C44.311 — Basal cell carcinoma of skin of nose

[TUMOR SITE / HISTORY / COMPLICATION DIAGNOSIS CODE(S), IF APPLICABLE]

L57.0 — Actinic keratosis; Z85.828 — Personal history of other malignant neoplasm of skin; Z79.01 — Long-term use of anticoagulants; Z95.0 — Presence of cardiac pacemaker

SO SIGNATURE

18 PROVIDER SIGN-OFF

PROVIDER NAME

Samuel Okafor

CREDENTIALS

MD, FACMS

SPECIALTY

Mohs Micrographic Surgery / Dermatologic Surgery

DATE

10/07/2026

TIME

13:35