Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

INPATIENT/OUTPATIENT

THYROID BIOPSY REQUISITION

Diagnostic Imaging – Ultrasound Department (Main Level) ☐ **IP**

Phone 905-883-2004 Fax 905-883-0772 ☐ **OP**

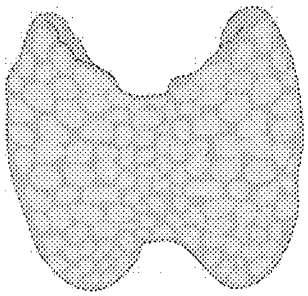
Referring Physician	Patient Information
Name:	Name:
Tel #:	Date of Birth:
Contact Person:	Mackenzie Health Medical Record Number:

BIOPSY

THYROID ☐
PARATHYROID ☐
LYMPH NODE ☐

Specify Location: _____

State reason for request: _____



Imaging Work-up: Has relevant imaging of the area to Bx been performed at Mackenzie Health? Yes ☐ No ☐

If no please arrange scan prior to Biopsy

Is Patient currently prescribed or taking blood thinners? Yes ☐ No ☐

If yes specify: _____

Others: ☐ _____

* Patients must not take aspirin, anti-coagulants five (5) days prior to biopsy.

Does the patient have any allergies? Yes ☐ No ☐

If yes, please name them: _____

Ordering Physician's Signature: _____