Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

OUTPATIENT

THYROID BIOPSY REQUISITION

Diagnostic Imaging – Ultrasound Department (Main Level)

Phone: 905-883-2004 Fax: 905-883-0772

Referring Physician	**Patient Information**
Name:	Name:
Telephone #:	Date of Birth: (dd/mm/yyyy)
Contact Person:	Mackenzie Health Medical Record Number:

Specify **Location** and **Size** of Nodules (include TI-RADS score for thyroid nodules):

BIOPSY

THYROID ☐

PARATHYROID ☐

LYMPH NODE ☐

OTHER (Specify) ☐ _____

When was the most **recent Ultrasound Scan** performed? _____(dd/mm/yyyy)
(If the outside US scan report and/or images are unavailable or if a TI-RADS score is unavailable, the patient may require a pre-approval scan at our center – Please inform the patient of the possibility of this. Please check the following box that you agree and acknowledge this: ☐)

Has a **recent aspiration** been performed? If so, please indicate the date: _____(dd/mm/yyyy)
(A repeat FNA for thyroid nodule(s) will be scheduled at least 3 months after this date to avoid false positives)

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

If yes specify: _____

Does the patient have any allergies? Yes ☐ No ☐

If yes, please name them: _____

Ordering Physician's Signature: _____