

Ultrasound Guided Thyroid FNA/Lymph Node Biopsy Requisition

Diagnostic Imaging – Ultrasound Department (Main Level)

Telephone: 905-883-2004

Fax: 905-883-0772

Patient Information	
Patient Name:	Date of Birth: (dd/mm/yyyy)
Patient Telephone Number:	Emergency Contact:
Address:	
Health Card Number:	Version Code:
Referring Physician	
Physician Name:	Telephone Number:
Contact Person:	

1. Please indicate the site for FNA:

- Thyroid
- Parathyroid
- Lymph Node
- Other (specify) _____

2. Please provide additional information regarding the **LOCATION** and **SIZE** of nodule(s)/lesion(s).

3. When was the most recent ultrasound scan performed (**please attach the report**)? _____

If the outside ultrasound images and/or report are unavailable, the patient may require a repeat ultrasound scan at our site prior to approval. Please inform the patient of the possibility of this.

4. Has an FNA been performed recently (within 3 months)?

- NO
- YES. Please provide the date: _____ (dd/mm/yyyy)

A repeat FNA will be scheduled at least 3 months after this date to avoid a false positive result.

5. Is the patient currently receiving anticoagulation (blood thinner)?

- NO
- YES. Please specify: _____

6. Does the patient have any allergies?

- No known allergies.
- YES. Please specify: _____

ALL the above information must be completed, or the requisition may be returned.

Ordering Physician's Signature: _____

