Alberta Health Services | Calgary Laboratory Services

Shaded areas are required information

FINE NEEDLE ASPIRATION CLINIC
PATIENT REFERRAL FORM*

PERSONAL HEALTH NUMBER (PHN)	____ ____ ____ ____ ____ – ____ ____ ____ ____	REGIONAL HEALTH RECORD NUMBER

ORDERING PHYSICIAN (Apply CLS Dr. Office Stamp Here):	PATIENT LAST NAME	FULL FIRST NAME	MIDDLE NAME
Last Name/Full First Name 5 Digit Client #: Alpha Suffix Provider #:	PATIENT ADDRESS	CITY, PROVINCE	POSTAL CODE

COPY TO:

1) ______ Last Name ______ Full First Name ______ Location

2) ______ Last Name ______ Full First Name ______ Location

CHART NUMBER	GENDER	DATE OF BIRTH	PATIENT PHONE NUMBER
		__ __ __ __ / __ __ __ / __ __ Y Y Y Y M M M D D	(__ __ __) __ __ __ - __ __ __ __

*** Note: FNA Clinic will accept patients with superficial/palpable lesions only**

CLINICAL INFORMATION (required for booking)

History of:

☐ Malignancy ______________________ (specify type of malignancy) ☐ Infection ☐ Immunosuppression

☐ Other: ______________________ (please specify)

Is the lesion palpable? ☐ Yes ☐ No

Is the patient currently on blood thinners (Heparin, Warfarin, Aspirin, etc.)? ☐ Yes ☐ No

Any known allergies? ☐ Yes ☐ No ______________________ (please specify)

Location of lesion: ______________________ (please specify)

Will the patient require a translator? ☐ Yes ☐ No ______________________ (please specify language)

FNA Clinic Location:

☐ **PLC OP Clinic 2: Fax completed form and pertinent Imaging Reports to CLS Cytopathology at 403-770-3319**

☐ **RR-ENT FNA Clinic: Fax completed form and pertinent Imaging Reports to RR-ENT Clinic at 403-955-8311**
(For use by ENT specialist only)

CLS Attending Pathologist (copy to):	Date and Time of Appointment:
______________________ (please print)	______ / ______ / ______ ______ : ______ YYYY MMM DD HH MM
	Date and Time of Procedure:
	______ / ______ / ______ ______ : ______ YYYY MMM DD HH MM

Clinibase Label	Accession Number