ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

NON ULTRASOUND GUIDED FINE NEEDLE ASPIRATION CLINIC PATIENT REFERRAL FORM

HIGHLIGHTED AREAS ARE REQUIRED INFORMATION

PERSONAL HEALTH NUMBER (PHN)	REGIONAL HEALTH RECORD NUMBER
___ ___ ___ ___ ___ ___ ___ ___ ___ ___	

ORDERING PHYSICIAN (Apply APL Dr. Office Stamp Here):

Last Name/Full First Name

5 Digit Client #:

Alpha Suffix Provider #:

PATIENT LAST NAME | **FULL FIRST NAME** | **MIDDLE NAME**

PATIENT ADDRESS | **CITY, PROVINCE** | **POSTAL CODE**

COPY TO:

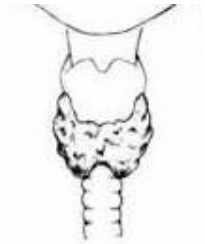
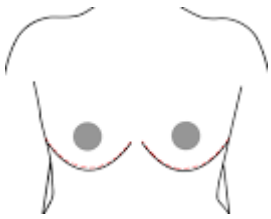
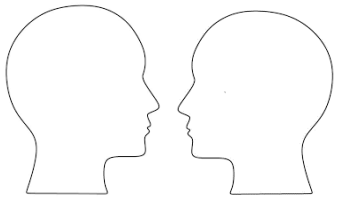
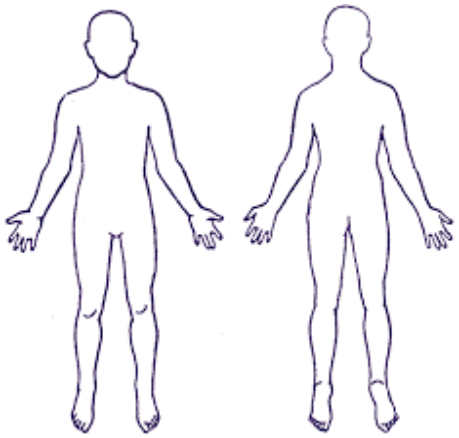
1) _____ _____ _____
Last Name | Full First Name | Office Address/Location

2) _____ _____ _____
Last Name | Full First Name | Office Address/Location

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

CLINICAL INFORMATION (required for booking)

1. **LOCATION OF LESION:** _____

2. **Is the lesion palpable?** Yes ☐ No ☐
3. **Is there a history of malignancy?** Yes ☐ No ☐ If yes, type:_____
4. **Currently on blood thinners?** Yes ☐ No ☐ If yes, date/time last dose:_____
5. **Allergy to anaesthesia?** Yes ☐ No ☐ If yes, specify:_____
6. **Radiology findings?** Yes ☐ No ☐ If yes, provide report:_____
7. **FNA Clinic "*Patient Instruction*" sheet provided?** Yes ☐ No ☐

FOR LAB USE ONLY:

Date of appointment:_____ **Time of appointment:**_____ **Time of procedure:**_____

APL Attending Pathologist :_____ **CytoTechnologist:**_____

Clinibase Label	Accession Number

FNA clinic
Phone: 403-770-3210
Fax: 403-770-3319