FNA Biopsy Referral Form

Please fax this referral to 212-639-6318.

MSK Fine Needle Aspiration Biopsy Clinic
530 East 74th Street
New York, NY 10021
Tel: 212-639-5990

PATIENT INFORMATION

Patient Name _____

DOB ___/___/_____ Gender ☐ M ☐ F

Parent/Guardian Name _____

Relationship _____

Street Address _____

City _____ State ____ Zip _____

Phone/Cell _____ Email _____

REFERRING MD CONTACT INFORMATION

Physician's Name _____

Office Address _____

City _____ State ____ Zip _____

Phone _____ Fax _____

Email _____

NPI Number _____

Tax ID Number _____

CLINICAL HISTORY

REQUESTED BIOPSY SITE

THYROID

Nodule #1:

☐Right L. ☐Left L. ☐Isthmus

☐Lower ☐Upper ☐Mid Pole

Size: _____mm

☐Solid ☐Cystic ☐Mixed

Sonographic Impression:

☐Benign ☐Suspicious ☐Indeterminate

Nodule #2:

☐Right L. ☐Left L. ☐Isthmus

☐Lower ☐Upper ☐Mid Pole

Size: _____mm

☐Solid ☐Cystic ☐Mixed

Sonographic Impression:

☐Benign ☐Suspicious ☐Indeterminate

SALIVARY GLAND

Parotid: **Submandibular Gland:**

☐Right ☐Left ☐Right ☐Left

LYMPH NODE

☐Right ☐Left

Level: ☐I ☐II ☐III ☐IV ☐V ☐VI

OTHER

Site:

If thyroid FNA results are **indeterminate** (Bethesda Category III or IV), please order molecular testing:

☐ Yes ☐No

If **Yes**, please indicate if you have any preferences for molecular testing: _____

MD Signature _____ **Date** _____ **Time** _____