MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Thyroid Diagnostic Clinic Referral Form

Fax: (416) 469-6154 **Tel: (416) 469-6580 x 2749**

Surname	Given Name	Birth Date dd/mm/yy	Gender M ☐ F ☐
Street	City	Postal Code	MRN
Home Phone ( )	Work ( )	OHIP Number	VC
Primary Contact Surname	Primary Contact Given Name	Home ( )	Relationship

Referring Physician Name	Physician Number	Date of Referral

PLEASE FAX ULTRASOUND AND BLOODWORK RESULTS WITH THIS REFERRAL FORM

Referral To: (Check please)

☐ **First available appointment** OR
☐ OTHNS (Dr Chiodo, Dr El Masri, Dr Hubbard, Dr Smith)
☐ Endocrinology (Dr Fine, Dr Fung, Dr Nicholas)

Reason for Referral:

☐ Palpable Thyroid Lump
☐ Thyroid Ultrasound Abnormality - (**Please Attach Reports**)
☐ Referral from Endocrine or Head & Neck Surgery for assessment
☐ Other (Please specify) _____

E.G. NECK MASS IN THE VICINITY OF THE THYROID GLAND

Please indicate Yes/No to the following:

Thyroid Ultrasound been done?	Y	N
Thyroid Function Tests been done?	Y	N
Thyroidectomy in the past	Y	N

Other Pertinent Information:

DAU Clinic Use