REQUEST FOR BIOPSY	❑ OP ❑ IP–Hospital_____Unit_____
Grand River Hospital Medical Imaging Department 835 King Street West Kitchener, ON N2G 1G3	**App't Date & Time:** **Fax Requests to (519) 749-4296**

ALL INFORMATION PROVIDED IS FOR THE CARE OF THE PATIENT

Referring Physician	Name (Last, first)
Procedure Requested	DOB: MI#

CRITICAL BOOKING INFORMATION- Incomplete information will result in request being returned-NO BOOKING

ORDERING PHYSICIAN OFFICE QUESTIONNAIRE:

PART A

1. **Is the patient able to understand English and sign consent?**
   ❑ Yes ❑ No. A family member or translator must accompany patient.
2. **Are there any previous medical conditions that we should be aware of?**
   ❑ No ❑ Yes. Specify:

   _____
3. **Is this biopsy required for:**
   ❑ Organ Function+/or Disease Process. **Must have complete clinical history for Pathology**. No need to complete PART B
   ❑ Mass. Must continue on to PART B
   ❑ Drainage. If drainage, answer below. No need to complete PART B
   ❑therapeutic ❑diagnostic Specify required lab work:

   _____

PART B:

1. **Relevant Prior Studies:**
   - All non Grand River Hospital reports must be submitted with the request.
   - All non Grand River Hospital/St. Mary's studies/films must be submitted prior to booking.

   ❑ GRH studies ❑ St. Mary's studies ❑ Other ❑ None

   Specify:_____ ❑ Studies/films to be sent to GRH

   ATT'N BIOPSY BOOKINGS
2. **Was this biopsy recommended by a GRH Radiologist?**
   ❑ No ❑ Yes

FOR GRAND RIVER HOSPITAL USE ONLY

Radiologist Reviewing:_____ Date:_____

Modality: ❑ CT ❑ US ❑ Fluoro

Comments:_____

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