

**Endocrinology Clinic**

**Fax: 504.903.1605**

**Fax this form with the Endocrinology Master Referral form when requesting an appointment.**



**Appendix: THYROID CARCINOMA**

Serum TSH and free T4 (or total T4) test results (current within the past 6 months) are required for this referral.

**Please indicate test results on this form or fax a copy of results with the Endocrine Clinic Referral Form if the results are not available in CLIQ.** Please have the patient bring copies of test results and all pathology reports, whole body scans and ultrasound images and reports to their appointment if they are not available at MCL.

Patient Name: \_\_\_\_\_ Date of Referral: \_\_\_/\_\_\_/\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ LIH Medical Record Number: \_\_\_\_\_

Test:	Result:	Range:	Date:
Serum TSH:	_____	___ - ___	___/___/___
Serum T4 (Free)	_____	___ - ___	___/___/___
Thyroglobulin antigen	_____	___ - ___	___/___/___
Thyroglobulin antibody:	_____	___ - ___	___/___/___