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lava

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PATHOLOGY / CYTOLOGY CONSULTATION REQUEST

Path No. _____

DATE / TIME COLLECTED	☐ Bill Patient (Self Pay) ☐ Bill Insurance	**Diagnosis**					
PATIENT LAST NAME	**FIRST**	**INITIAL**	**PATIENT PHONE NO.**		**PATIENT SOC. SEC. NO.**		
PATIENT ADDRESS	**CITY**	**STATE**	**ZIP**	**BIRTH DATE**	**AGE**	**SEX**	
RESPONSIBLE PARTY / GUARANTOR			**GUARANTOR PHONE NO.**		**GUARANTOR SOC. SEC. NO.**		
GUARANTOR ADDRESS	**CITY**	**STATE**	**ZIP**	**PHYSICIAN**			
INSURANCE COMPANY (attach copies of ID Cards) . primary /secondary)			**POLICY NO. / GROUP NO.**		**MEDICARE NO.**		
EMPLOYER NAME & PHONE NO. (WORK COMP. CASES ONLY)			**CLERK / RN SIGN**		**MEDICAL NO.**		

NON GYN CYTOLOGY REQUEST

SOURCE

	Left	Right
☐ BREAST	☐	☐
☐ NIPPLE	☐	☐
☐ BRONCHUS	☐	☐
☐ PLEURAL FLUID	☐	☐
☐ THYROID	☐	☐
☐ URINE		
☐ SPUTUM		
☐ PERITONEAL FLUID		
☐ CSF		
☐ OTHER. SPECIFY: _____		

COLLECTION METHOD

- ☐ FNA
  - SITE: _____
- ☐ BRUSHING
- ☐ WASHING
- ☐ VOIDED
- ☐ CATHETERIZED
- ☐ SMEAR
- ☐ SCRAPING
- ☐ OTHER. SPECIFY: _____

# of SPECIMENS _____

BIOPSY REQUEST

# of SPECIMENS

Site(S) 1. _____

2. _____

3. _____

4. _____

5. _____

Preoperative Diagnosis: _____

Postoperative Diagnosis: _____

_____ Physician Signature: _____

WHITE - Department Copy YELLOW - Billing Copy PINK - Doctor's Office / Nurse's Copy