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Non-Gynecologic

SPECIMEN FOR CYTOLOGICAL DIAGNOSIS

The following information must be completed in full using labels, label all copies:

Patient Name ______________________________

Date of Birth ______________ Social Security # ______________ Sex ______

Chart # ______________ Hosp/Clinic ID# ______________

Date Specimen Obtained ______________________________

DO NOT WRITE HERE

Acc# ______________

Date Rcd ______________

# of Containers Rcd ______

# of Slides Processed ______

Ordering Physician ______________________________ UPIN # ______________

Referring Clinic/Hospital ______________ Phone: ______________ Inpatient ______ Outpatient ______

Primary or Referring Physician ______________________________

Address ______________________________ Phone ______________

FAX Report _____ Yes FAX # ______________

Insurance Information:

Guarantor Name ______________ Relationship ______________ Phone (_____) ______________

Address ______________ City ______________ State ______ Zip ______________

Medicare # ______________ BC/BS# ______________ ND _____ MN _____

Welfare ND ____ MN ____ County ______________ Number ______________

Other Insurance:

Subscriber ______________ Company ______________ Ins # ______________

PROVIDER ORDERS

Specimen Source: Non-Gyn

Breast:	☐ Aspirate	☐ Nipple Discharge	
Bronchial:	☐ Brush	☐ Wash	☐ BAL
Effusion:	☐ Pleural	☐ Abdominal	☐ Pericardial
Esophageal:	☐ Brush	☐ Wash	
Gastric:	☐ Brush	☐ Wash	
Spinal:	☐		
Sputum:	☐		
Synovial:	☐		
Urine:	☐ Voided	☐ Catheter	☐ Bladder Wash
Thyroid FNA:	☐		

Fine Needle Aspiration: ______________________________

Miscellaneous Smears: ______________________________

*Preserve all fluid specimens with equal amounts of 50% alcohol

*Preserve all prepared smears immediately with Cytology spray fixative

Clinical History: **(Must fill out.)**

REQUIRED: Ordering Provider

____
Signature

Date: ______________

Time: ______________

Tech Comments:

Do Not Write Below This Line.

CPT

____88104	____88173
____88108	____88305
____88160	____88312
____88161	____88313

Diagnosis / Comments:

Pathologist ______________________________

Date ______________

Non-Gynecologic
Specimen for cytological diagnosis

T-7015-0008

W7015-0008 MAY 08