

PART A: Patient Information - *Required*

Patient Name: _____
 Date of Birth _____ Gender M ___ F ___
 Address: _____
 City _____ State _____ Zip Code _____
 Social Security: _____ EMR# _____
 Specimen collection date: _____

PART B: Provider Information - *Required*

Provider: _____
 Address: _____
 City _____ State _____ Zip Code _____
 Phone: _____ Fax: _____
 NPI# _____ Signature _____

Send Duplicate Report to: Name _____ Address/Fax _____

PART C: Indications/Clinical History: _____

ICD-10 Code (*Required*): 1) _____ 2) _____ 3) _____ 4) _____

PART D: Insurance Billing Information:

Send Bill to: Patient: _____ Insurance: _____

Name of Primary Insurance CO _____ Insured ID _____ Group # _____

Relationship to Insured Self Spouse Child Other

Insured's Name _____ Insured Date of Birth ____/____/____

Please Attach: 1) A copy of the front/back of patient's insurance card(s) or 2) Printout patient demographics and insurance information from your EHR

PART E: Biopsy Specimen Information:

No. of Container: _____

A: _____ D: _____ NOTE:

B: _____ E: _____

C: _____ F: _____

PART F: Cytology Sp Information: # of Container: _____ # of slides: _____

1: Urine Cytology _____ FISH _____ Void: _____ Instrument: _____

(Please submit in sterile urine container or Cytolyte)

2: Thyroid Site A: _____ Site B: _____ Site C: _____

(Please prep 1-2 airdried slide and make additional passes to put in Cytolyte)

3: Breast Site A: _____ Site B: _____ Cystic: _____ Solid: _____

(Please put all aspiration material in Cytolyte)

4: Other: _____ Site: _____ *(Please prep 1-2 airdried slide and make additional passes to put in Cytolyte)*

FOR LAB USE ONLY:

Receiving Date: _____ Time: _____ Accession# _____ Note: _____