

PATIENT INFORMATION					
Last Name		First Name		M.I.	
Street Address				Apt. #	
City			State	Zip	
Patient Phone Number			Patient Social Security Number		
Date of Birth / /	Age	Sex	Client ID #	Collection Date	

CLIENT INFORMATION	
Treating Physician	UPIN #
Physician's Signature X _____	

BILLING / INSURANCE (or attach copy of insurance card - both sides)	
Bill:	Insurance <input type="checkbox"/> Secondary Insurance Information Attached
<input type="checkbox"/> Insurance	Name/Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
<input type="checkbox"/> Medicare	
<input type="checkbox"/> Medicaid	Company Name
<input type="checkbox"/> Worker's Comp	Address
<input type="checkbox"/> Patient	City
<input type="checkbox"/> Physician	State
<input type="checkbox"/> Hospital	Zip
<input type="checkbox"/> Other	Employer Name
<input type="checkbox"/> Inpatient	Group/Contract #
<input type="checkbox"/> Outpatient	Member ID #
<input type="checkbox"/> Emergency Room	Medicare #
	Medicaid ID #

Send Duplicate of Report to:

Name _____

Address/Fax _____

ICD-9 CODE (Required) _____

LAB USE ONLY	REC'D DATE:	REC'D TIME:	ACCESSION #:	TECH. INITIALS:
Interpretation	<input type="checkbox"/> Guided FNA	<input type="checkbox"/> Frozen	F Rec Time _____	F Result Time _____
Slide Count _____				

SPECIMEN SITE

HISTORY AND CLINICAL DIAGNOSIS

ENDOSCOPIC FINDINGS

Specific Questions for Pathologist _____

SPECIMENS	
1 _____	5 _____
2 _____	6 _____
3 _____	7 _____
4 _____	8 _____

SPECIAL TESTING - REQUIRES TISSUE TRANSPORT MEDIA	
<input type="checkbox"/> Flow Cytometry/Immunophenotyping	<input type="checkbox"/> Cytogenetic/Karyotype Analysis
Date Collected: _____ Time: _____ By: _____	