CBM | PATHOLOGY

CYTOLOGY, BIOPSY, MICROSCOPY
18207A Flower Hill Way
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REFERRING/ORDERING M.D.: **UPIN#:**	SIGNATURE OF ORDERING M.D. *(or designated person)*
ADDRESS:	ADDITIONAL M.D. NAME AND ADDRESS:

PATIENT LAST NAME: FIRST: MI:
Sex: M F

PATIENT SOCIAL SECURITY#: | DATE OF BIRTH: __/__/____

PATIENT'S COMPLETE ADDRESS:

*NAME OF INSURED/RESPONSIBLE PARTY(*last, first, MI*) (If other than patient)*

ADDRESS OF INSURED/RESPONSIBLE PARTY:

PATIENT/RESPONSIBLE PERSON SIGNATURE:

BILL TO: ___PATIENT ___INSURANCE *(fill information below or attach a copy of the patient's information sheet **and** attach a copy of the insurance card(s), front and back)*

INSURED SOCIAL SECURITY # *(if not patient)*:

MEDICARE #: MEDICAID#

PRIMARY INSURANCE Relationship to insured: __SELF __SPOUSE __DEPENDENT

INSURANCE COMPANY NAME:_____
MEMBER/INSURED ID#:_____ GROUP #:_____
HMO / PPO *(circle)*
INSURANCE ADDRESS:

SECOND INSURANCE Relationship to insured: __SELF __SPOUSE __DEPENDENT

INSURANCE COMPANY NAME:_____
MEMBER/INSURED ID#:_____ GROUP #:_____
HMO / PPO *(circle)*
INSURANCE ADDRESS:

FINE NEEDLE ASPIRATION & NON-GYN CYTOLOGY REQUISITION FORM

COLLECTION DATE: ___/___/_____

ICD-9 CODE(S):

SPECIMEN SOURCE (*circle and fill in if appropriate)*:

FNA (site of aspiration)_____

Bronchial => brushing / washing => (R) (L)
Corneal scraping
CSF fluid
Esophageal brush/wash
Gastric brush/wash
Nipple discharge
Peritoneal fluid
Pleural fluid
Sputum (induced)
Urine: voided
catheterized
bladder wash
OTHER (source):
_____

SURGICAL BIOPSY ALSO SUBMITTED: ___

CLINICAL DATA:

PREVIOUS CASES: Date: __/__/___ Site:_____
Diagnosis:_____

CURRENT MEDICAL HX:_____

PREVIOUS MEDICAL HX:_____

SPECIAL REQUESTS:_____

PRELIMINARY DIAGNOSIS (do not write in this space, lab use only)