

*The Area Above This Line Is For Lab Use Only*



20 Northpointe Parkway - Suite 100  
 Amherst, NY 14228  
 (716) 250-9235 Fax (716) 250-9242

Date Collected

Date Received (Lab Use)

Ordering Physician / Client

Authorized Signature (required)

**PLEASE PRINT ALL INFORMATION CLEARLY**

Patient Name	Last	First
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Address	
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City State Zip	
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D.O.B.	Sex	Phone
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MEDICARE #	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Regular (Part B) <input type="checkbox"/> Railroad
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MEDICAID #	
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ICD-10 Code (Mandatory)	ICD-10 Code	ICD-10 Code	ICD-10 Code
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**COPY OF REPORT TO: (FAX NUMBER MUST BE PROVIDED)**

NAME	FAX #
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NAME	FAX #
------	-------

NAME	FAX #
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<input type="checkbox"/> Insurance	<input type="checkbox"/> Patient	<input type="checkbox"/> Client
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**PRIMARY INSURANCE INFORMATION**

Insurance Company
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Contract/ID/Policy #	Group #
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Name of Insured
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Employer
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Relationship to Insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
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**SECONDARY INSURANCE INFORMATION**

Insurance Company
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SPECIAL INSTRUCTIONS / COMMENTS / CLINICAL HISTORY:
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**TISSUE PATHOLOGY (BIOPSY) PLEASE INDICATE SPECIMEN TYPE (EXACT ANATOMIC LOCATIONS)**

<b>A</b>	<b>E</b>	<b>I</b>
<b>B</b>	<b>F</b>	<b>J</b>
<b>C</b>	<b>G</b>	<b>K</b>
<b>D</b>	<b>H</b>	<b>L</b>

**NON-GYN CYTOLOGY**

<input type="checkbox"/> BREAST FNA <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> THYROID FNA <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT SPECIMEN TYPE / LOCATION:	<input type="checkbox"/> BREAST FNA <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> THYROID FNA <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT SPECIMEN TYPE / LOCATION:	<input type="checkbox"/> FNA, OTHER SPECIMEN TYPE / LOCATION:
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<input type="checkbox"/> WASHINGS SOURCE:	<input type="checkbox"/> BRUSHINGS SOURCE:	<input type="checkbox"/> DIRECT SMEAR(S) SOURCE:	<input type="checkbox"/> URINE CYTOLOGY ADDITIONAL TESTS:
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