

Patient Information		Provider Information	
Name:		Clinician Signature REQUIRED: Date	
Address:			
City, State, Zip Code:			
Phone Number:	Social Security Number:	Copy To: _____ Fax: _____	
Date Of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		
Specimen Collection Date:		Diagnosis/ICD-10 Codes REQUIRED:	

Billing/Insurance (or attach copy of insurance card, front and back)			
Bill: <input type="checkbox"/> Insurance <input type="checkbox"/> Self-Pay <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	Insurance:		
	Name/Relationship to Insured:		
	Company Name:		Employer Name:
	Address:		Policy/Group #
	City:	State:	Zip Code: _____ Medicare # _____ Medicaid # _____

Cytology	Clinical History	Surgical Pathology / Histology
<input type="checkbox"/> FNA site: _____ # of slides: Fixed _____ # of slides: Air Dried _____ <input type="checkbox"/> Cytolyt <input type="checkbox"/> Urine <input type="checkbox"/> Cyst aspirate site: _____	_____ _____ _____ _____ _____ _____ _____	Tissue Submitted: List Specimen Source 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____