University Hospitals
Elyria Medical Center

LABORATORY ORDER
Histology/Cytology Non-GYN

Place LIS Label Here (Lab Use Only)

University Hospitals Elyria Medical Center● 630 East River St. ● Elyria, OH 44035 ● 440/329-7531 ● Fax 440/329-7685
University Hospitals Amherst Health Center● 254 Cleveland Avenue ● Amherst, OH 44001 ● 440/988-6176 ● Fax 440/988-6017
University Hospitals Avon Health Center ● 1997 Healthway Dr. ● Avon , OH 44011● 440/988-6940● Fax 440/988-6945

Patients Name	(First)	(MI)	Sex	Date of Birth	Social Security

Patient Address (street) (City) (St) (Zip)	Area code/Phone

Parent or Guardian (if minor)

ICD-10 Codes(s) with full diagnosis description.

Standing Order: Indicate frequency, Starting Date and Ending Date of Order. Maximum length 1 year.
Frequency: Start Date: End Date:

Type of Exam:	PAT Scheduled (EMH 329-7576 or AH 988-6100)
☐ Screening ☐ Diagnosis ☐ Pre-Operative	Date: _____ Time: _____

Physician's Signature (Required)	Date of Order	Date of Collection

Bill Services To:
☐ Physician/Client ☐ Patient ☐ Insurance*Attach copy of insurance card front & back.* ☐ Other (*specify*)

Ordering Physician Name
(First and Last name- please print)

NPI:
Phone:
Fax:

To expedite please provide a copy of the insurance card front and back. If available include a Photo Id.

Orders must include:
Physician' s Signature
Patient demographics
Codeable diagnosis
All Samples must be labeled:
Patient's full legal name
Date of birth
Collection date and time
Collector's Initials

Write the patient's name in pencil on the frosted end of the slide(s).

HISTOLOGY (SURSP)

Tissue or Biopsy site Information:
A.
B.
C.
D.
E.
F.
G.
H.
History:
Pre-Operative Diagnosis:
Operation:
Post-Operative Diagnosis:
For breast mass include the following:
Time removed:
Time in Formalin:

NON-GYN CYTOLOGY(MEDSP)

Source of Specimen:
[ ] Bronchial brushing: __Left ___Right
Lobe: __Upper ___Middle ___Lower
[ ] Bronchial washing: __Left __Right
Lobe: __Upper ___Middle __Lower
[ ] Esophageal: ___Washing
___Brushing
[ ] Breast: __Left __Right
[ ] Neck mass : __Left __Right
[ ] Nipple: __Left __Right
[ ] Ovary: __ Left __Right
[ ] Pelvic fluid: __Left __Right
[ ] Peritoneal (Paracentesis) fluid: __Left __Right
[ ] Pleural (Thorancentesis) fluid: __Left __Right
[ ] Gastric
[ ] Thyroid: __Left __Right
[ ] Sputum : __Left __Right
[ ] Urine:
___Bladder ___Catheter
___Midstream ___Random
Other:

Additional billing may apply if special studies are indicated. 3/31/17