


AP Label	 Penn Medicine Penn Presbyterian Medical Center Franz Fogt, M.D., Dr.med. Director 51 No. 39th Street, Philadelphia, PA 19104 Phone: 215.662.8963; Fax: 215.662.1694 Cytopathology Non-Tissue Specimens Only	<p style="text-align: center;">PLACE PATIENT LABEL COMPLETE THE FOLLOWING IF LABEL UNAVAILABLE</p> Name _____ DOB _____ Address _____ Age _____ Medical Record No. _____ Sex _____
		Page # _____ of _____

Date of Operation/Procedure: _____	OR# or Clinic Location: _____	Operation/Procedure: _____
------------------------------------	-------------------------------	----------------------------

PLEASE PRINT
Ordering Clinician Name: _____
Additional Reports to: _____
Attending Surgeon / Proceduralist Name and Cell Phone #: _____

Clinical History: (Include prior pathologic diagnoses; include LMP if appropriate)	ICD-10 _____
Previous Cytology: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify: _____ Infectious Precautions: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify: _____ Previous Chemotherapy: <input type="checkbox"/> No <input type="checkbox"/> Yes Previous Radiation: <input type="checkbox"/> No <input type="checkbox"/> Yes Hormones: <input type="checkbox"/> No <input type="checkbox"/> Yes Additional Clinical History: _____	

Specific question(s) to be answered by consultation, including special studies:

Perform Molecular Testing, when clinically appropriate, as outlined in "Molecular Profile Algorithm" policy.

Rule Out Lymphoma (In Normosol)

Other

Aspiration (FNA)	Fluid	GI Brushing	Respiratory	Urinary																																																																						
<table style="width:100%; border: none;"> <tr><td style="width:50%; text-align: center;">Right Left</td><td style="width:50%; text-align: center;">Right Left</td></tr> <tr><td><input type="checkbox"/> Breast</td><td><input type="checkbox"/> Pleural</td></tr> <tr><td><input type="checkbox"/> Parotid</td><td><input type="checkbox"/> Abdominal Wash</td></tr> <tr><td><input type="checkbox"/> Kidney</td><td><input type="checkbox"/> CSF</td></tr> <tr><td><input type="checkbox"/> Lung</td><td><input type="checkbox"/> Pericardial</td></tr> <tr><td><input type="checkbox"/> Thyroid</td><td><input type="checkbox"/> Peritoneal / Ascites</td></tr> <tr><td><input type="checkbox"/> Head/Neck</td><td><input type="checkbox"/> Pelvic wash</td></tr> <tr><td><input type="checkbox"/> Liver</td><td></td></tr> <tr><td><input type="checkbox"/> Lymph Node _____</td><td></td></tr> <tr><td><input type="checkbox"/> Pancreas</td><td></td></tr> </table>	Right Left	Right Left	<input type="checkbox"/> Breast	<input type="checkbox"/> Pleural	<input type="checkbox"/> Parotid	<input type="checkbox"/> Abdominal Wash	<input type="checkbox"/> Kidney	<input type="checkbox"/> CSF	<input type="checkbox"/> Lung	<input type="checkbox"/> Pericardial	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Peritoneal / Ascites	<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Pelvic wash	<input type="checkbox"/> Liver		<input type="checkbox"/> Lymph Node _____		<input type="checkbox"/> Pancreas			<input type="checkbox"/> Bile <input type="checkbox"/> Colon <input type="checkbox"/> Esophageal <input type="checkbox"/> Gastric <input type="checkbox"/> Rectal	<table style="width:100%; border: none;"> <tr><td style="width:12.5%; text-align: center;">RUL</td><td style="width:12.5%; text-align: center;">RML</td><td style="width:12.5%; text-align: center;">RLL</td><td style="width:12.5%; text-align: center;">LUL</td><td style="width:12.5%; text-align: center;">LLL</td></tr> <tr><td colspan="5"><input type="checkbox"/> Bronchial Brush</td></tr> <tr><td colspan="5"><input type="checkbox"/> Bronchial Wash</td></tr> <tr><td colspan="5"><input type="checkbox"/> Bronchioloalveolar Lavage</td></tr> <tr><td colspan="5"><input type="checkbox"/> Sputum - Spontaneous</td></tr> <tr><td colspan="5"><input type="checkbox"/> Sputum - Induced</td></tr> <tr><td colspan="5"><input type="checkbox"/> Tracheal Wash</td></tr> <tr><td colspan="5"><input type="checkbox"/> Pneumocystis</td></tr> </table>	RUL	RML	RLL	LUL	LLL	<input type="checkbox"/> Bronchial Brush					<input type="checkbox"/> Bronchial Wash					<input type="checkbox"/> Bronchioloalveolar Lavage					<input type="checkbox"/> Sputum - Spontaneous					<input type="checkbox"/> Sputum - Induced					<input type="checkbox"/> Tracheal Wash					<input type="checkbox"/> Pneumocystis					<table style="width:100%; border: none;"> <tr><td style="width:50%; text-align: center;">Right</td><td style="width:50%; text-align: center;">Left</td></tr> <tr><td><input type="checkbox"/> Renal Pelvis</td><td><input type="checkbox"/> Renal Wash</td></tr> <tr><td><input type="checkbox"/> Ureter</td><td><input type="checkbox"/> Bladder Wash</td></tr> <tr><td><input type="checkbox"/> Urine - Voided</td><td><input type="checkbox"/> Urine - Catheterized</td></tr> <tr><td><input type="checkbox"/> Loop Bag</td><td><input type="checkbox"/> UroVysion (FISH)</td></tr> </table>	Right	Left	<input type="checkbox"/> Renal Pelvis	<input type="checkbox"/> Renal Wash	<input type="checkbox"/> Ureter	<input type="checkbox"/> Bladder Wash	<input type="checkbox"/> Urine - Voided	<input type="checkbox"/> Urine - Catheterized	<input type="checkbox"/> Loop Bag	<input type="checkbox"/> UroVysion (FISH)
Right Left	Right Left																																																																									
<input type="checkbox"/> Breast	<input type="checkbox"/> Pleural																																																																									
<input type="checkbox"/> Parotid	<input type="checkbox"/> Abdominal Wash																																																																									
<input type="checkbox"/> Kidney	<input type="checkbox"/> CSF																																																																									
<input type="checkbox"/> Lung	<input type="checkbox"/> Pericardial																																																																									
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Peritoneal / Ascites																																																																									
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Pelvic wash																																																																									
<input type="checkbox"/> Liver																																																																										
<input type="checkbox"/> Lymph Node _____																																																																										
<input type="checkbox"/> Pancreas																																																																										
RUL	RML	RLL	LUL	LLL																																																																						
<input type="checkbox"/> Bronchial Brush																																																																										
<input type="checkbox"/> Bronchial Wash																																																																										
<input type="checkbox"/> Bronchioloalveolar Lavage																																																																										
<input type="checkbox"/> Sputum - Spontaneous																																																																										
<input type="checkbox"/> Sputum - Induced																																																																										
<input type="checkbox"/> Tracheal Wash																																																																										
<input type="checkbox"/> Pneumocystis																																																																										
Right	Left																																																																									
<input type="checkbox"/> Renal Pelvis	<input type="checkbox"/> Renal Wash																																																																									
<input type="checkbox"/> Ureter	<input type="checkbox"/> Bladder Wash																																																																									
<input type="checkbox"/> Urine - Voided	<input type="checkbox"/> Urine - Catheterized																																																																									
<input type="checkbox"/> Loop Bag	<input type="checkbox"/> UroVysion (FISH)																																																																									

Other / Not listed above (please print)

Person completing this form Print name _____	Person sending the specimen if different from person completing this form Print name _____	If applicable, person hand-delivering the specimen Print name _____
---	--	---

FOR PATHOLOGY USE ONLY IN THIS BOX

Fine Needle Aspiration Assessment							
Number of Passes: _____	Site: _____	Performed by: _____					
1. _____ 2. _____ 3. _____	4. _____ 5. _____ 6. _____	<table style="border: none;"> <tr><td style="text-align: center;">Billing</td></tr> <tr><td style="text-align: center;">88173 (x1)</td></tr> <tr><td style="text-align: center;">88172 (x1)</td></tr> <tr><td style="text-align: center;">88177 (x__)</td></tr> <tr><td style="text-align: center;">10021 (x1)</td></tr> </table>	Billing	88173 (x1)	88172 (x1)	88177 (x__)	10021 (x1)
Billing							
88173 (x1)							
88172 (x1)							
88177 (x__)							
10021 (x1)							
Impression: _____ Pathologist(s): _____ CP CPI							
Service: 1 2 3 4 # Slides: Fixed _____ Air Dried _____ Separate specimen for: _____							
#Containers: Fresh(Normosol) _____ Fixed(Cytolyt) _____ Fluid Volume: _____ #Slides: Fixed _____ Air Dried _____							
Picked up / Received by: _____		Total Number of Specimens picked up/received: _____					