ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform cytopathology testing.
For electronic orders only, please fill out and submit with the electronic packing list.

PATIENT HISTORY FOR NON-GYNECOLOGIC CYTOPATHOLOGY TESTING

Client Number _____ **Specimen Collection Date** _____**Time**_____

Patient Name _____**Date of Birth** _____ **Sex** _____

Patient Medical Record Number (mandatory)_____

Patient ID Number_____ **Lab ID Number**_____

Referring Physician_____ **Phone (_____)**_____

Please [ ] Call [ ] Fax results to: _____ **at (_____)** _____

ICD-9 Codes (List all that apply) _____

Non-gynecologic clinical history: _____
_____

Circle the cytopathology test you intend to order and indicate the source:

2000623 Non-Gynecologic Testing Source Required:	**2002528 Pancreatobiliary FISH** Source_____ Fixative _____
__Anal	
__Bile Drainage __Bile Duct Brush	**2001181 UroVysion FISH** Source_____ Fixative _____
__Bladder Washing	
__Bronchial: Wash / Brush: L / R	**2000183 Bladder Tumor Associated Antigen**
__Bronchoalveolar Lavage: Site_____	
__Cerebrospinal Fluid __Conjunctival Scraping L / R	**2000443 Fine-Needle Aspirate** Source Required:
__Esophageal: Wash / Brush	__Breast L / R
__Gastric: Wash / Brush	__Kidney L / R
__Nipple Secretion L / R	__Liver
__Oral Cavity: Wash / Brush	__Lung L / R
__Pelvic Washing	__Ovary L / R
__Pericardial Fluid	__Pancreas
__Peritoneal Fluid	__Salivary Gland: Site_____
__Pleural Fluid L / R	__Thyroid L / R
__Renal Pelvis: Wash / Brush: L / R	__Lymph Node: Site_____
__Skin Scraping: Site_____	__Lymph Node: Site_____
__Sputum	__Lymph Node: Site_____
__Synovial Fluid	__Other_____
__Tzanck Smear: Site_____	__Other_____
__Ureteral: Wash / Brush: L / R	
__Urethral Wash	**2000181 Non-Gynecologic Consult**: Site_____
__Urine, Catheterized	Number of Slides_____ Number of Blocks_____
__Urine, Voided	Copy of Report: Cytopathology_____
__Vitreous Fluid L / R	Surgical Pathology_____

Master Label