Patient Name: ____________________

DOB: ________ Age: ________ ☐ M ☐ F

SS#: ____________________

Address: ____________________

____

Sarah Bush Lincoln
Laboratory Services
1000 Health Center Drive
P.O. Box 372
Mattoon, IL 61938
(217) 258-2247 Phone
(217)238-4584 Fax

Subm Client: ____________________

Submitting Physician (printed) ____________________

Submitting Physician (signature) ____________________

Bill to: ☐ Account
☐ Medicare ____________________
☐ Medicaid ____________________
☐ Insurance ____________________

Request to bill insurance must have a copy of patient's insurance card attached.

Date Collected: ____________________

Date Received: ____________________

Brief Clinical History:

Diagnosis Code: ____________________

Diagnosis Code: ____________________

Specimen Source/Procedure

- ☐ Urine
  - ☐ Voided
  - ☐ Instrumentation or Washing
- ☐ Fine Needle Aspiration
  - ☐ Source ____________
- ☐ Paracentesis
- ☐ Pericardial
- ☐ Thoracentesis
  - ☐ Right
  - ☐ Left
- ☐ Sputum
- ☐ Bronchial Wash/Brush
  - ☐ Right
  - ☐ Left
- ☐ Breast
  - ☐ Right
  - ☐ Left
- ☐ Ovary
  - ☐ Right
  - ☐ Left
- ☐ Cul de sac
- ☐ Pelvic Gutter
  - ☐ Right
  - ☐ Left
- ☐ Esophageal
- ☐ Gastric
- ☐ Bile Duct Brushings
- ☐ Pap
  - ☐ Source ____________
- ☐ Other....... Site: ____________
- ☐ CSF

Cytology Report

Gross Description:

Statement of specimen adequacy:
- ☐ Satisfactory for interpretation
- ☐ Less than optimal
- ☐ Unsatisfactory

Explanation for less than optimal or unsatisfactory:
- ☐ Scant cellularity
- ☐ Poor fixation or preservation
- ☐ Presence of foreign material
- ☐ Obscuring inflammation
- ☐ Obscuring blood
- ☐ Excessive cytolysis or autolysis
- ☐ Not representative of anatomic site
- ☐ Other specify: (see comments)

Effective Date: 7/24/12
Revision Date: 3/25/21, 1/3/24
100010-A

CYTOLOGY REQUEST FORM