

Facility Name

Facility Address

Facility Phone Number

Provider Full Name

Provider NPI

STAT DUPLICATE REPORT TO:

NONGYN CYTOLOGY REQUEST		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	RACE	SEX
SOCIAL SECURITY NUMBER		
PATIENT ID#		

BILLING INFORMATION	
PATIENT ADDRESS	APT. #
CITY	STATE ZIP
HOME PHONE#	WORK PHONE#
BILL TO (PLEASE CIRCLE)	
<input type="checkbox"/> DOCTOR <input type="checkbox"/> PATIENT <input type="checkbox"/> CHP <input type="checkbox"/> MCR <input type="checkbox"/> MCD <input type="checkbox"/> OTHER	
PRIMARY INSURANCE NAME	

SPECIMEN INFORMATION
DATE TAKEN: _____ / ____ / ____
GYN: <input type="checkbox"/> VAG. <input type="checkbox"/> CERVIX <input type="checkbox"/> ENDOCX LMP: _____
SPUTUM: <input type="checkbox"/> <input type="checkbox"/> TZANK SMEAR/SOURCE: _____
BRONCHOSCOPIC:
<input type="checkbox"/> TRACHEA <input type="checkbox"/> RT. BRONCH. <input type="checkbox"/> LT. BRONCH.
<input type="checkbox"/> WASHING <input type="checkbox"/> BRUSHING <input type="checkbox"/> OTHER
URINE: <input type="checkbox"/> VOIDED <input type="checkbox"/> CATHETER <input type="checkbox"/> BLADDER WASHING
<input type="checkbox"/> CYSTO <input type="checkbox"/> URETER <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT
GI: <input type="checkbox"/> ESOPHAGUS <input type="checkbox"/> COLON <input type="checkbox"/> GASTRIC
BODY CAVITY: <input type="checkbox"/> PERITONEAL <input type="checkbox"/> PLEURAL <input type="checkbox"/> PERICARDIAL
<input type="checkbox"/> PERITONEAL/PELVIC WASHING
BREAST: <input type="checkbox"/> RT. NIPPLE DISCHARGE <input type="checkbox"/> LT. NIPPLE DISCHARGE
CEREBROSPINAL FLUID: <input type="checkbox"/>
FINE NEEDLE ASPIRATION: <input type="checkbox"/> CYST <input type="checkbox"/> SOLID
SITE: _____

ADDRESS	
INSURED NAME	
ID #	GROUP #

OTHER:
SPECIMEN SUBMITTED FLUID: FIXATIVE ADDED _____ ML <input type="checkbox"/> 50% ALCOHOL <input type="checkbox"/> CYTORICH RED <input type="checkbox"/> CYTOLYT SLIDES: <input type="checkbox"/> AIR DRIED # _____ <input type="checkbox"/> SPRAY FIXED # _____

CLINICAL INFORMATION
<input type="checkbox"/> ABNORMAL BLEEDING <input type="checkbox"/> MASS - R/O TUMOR <input type="checkbox"/> PAINFUL/FREQUENT URINATION <input type="checkbox"/> R/O INFECTION <input type="checkbox"/> OTHER: _____
HISTORY OF CANCER: _____ TYPE AND YEAR OF DX
PREVIOUS CYTOLOGY / HISTOLOGY
DATE(S): _____
ACCESSION#(S): _____

LAB USE ONLY	SPECIMEN DESCRIPTION
COLOR: _____	VOLUME: _____
CONSISTENCY: _____	
SLIDES: _____	FIXED: _____ AIR DRIED: _____
MATERIALS PREPARED	
CYTOSPINS: _____	THINPREP: _____ SUREPATH: _____
CELL BLOCK: _____	SILVER STAIN: _____
PAP STAIN: _____	ROMANOWSKY STAIN: _____
PREPARED BY: _____	

CYTO PATHOLOGIC DIAGNOSIS
DATES: _____ TECH(S): _____
FOR BARCODE LABEL ONLY
