NON-GYNECOLOGIC CYTOPATHOLOGY/MICROBIOLOGY REQUISITION

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Patient________________________________ DOB____/____/_____ AGE_____ Sex___ SSN_________________ Date_______________

Patient Phone #_______________Patient Address_________________________________ City _______________State ___________Zip_______

Primary Insurance_______________________________ Policy #___________________________ Group #_______________________________

Subscriber_______________________________ Relation to Patient____

Secondary Insurance____________________________ Policy #___________________________ Group#________________________________

Subscriber_______________________________ Relation to patient____

Clinical History (symptoms/screening): ____

Urine Specimen #1: ☐ Voided ☐ Clean Catch ☐ Catheterized ☐ Bladder Wash ☐ Other _______________________
Urine Specimen #2 ☐ Voided ☐ Clean Catch ☐ Catheterized ☐ Bladder Wash ☐ Other _______________________

Respiratory: ☐ Sputum ☐ Bronchial Brush Source:________________________
☐ Bronchial Wash Source: ________________________ ☐ BAL Source: _________________________________

Fluids: ☐ Pleural ☐ Peritoneal ☐ CSF ☐ Other (specify)____

Washings: ☐ Pelvic ☐ Peritoneal ☐ Other (specify)____

Thyroid Site #1: ☐ Left ☐ Right ☐ Isthmus ☐ Cyst ☐ Nodule

Thyroid Site #2: ☐ Left ☐ Right ☐ Isthmus ☐ Cyst ☐ Nodule

Breast: ☐ Left ☐ Right ☐ Cyst fluid ☐ FNA of Mass ☐ Nipple Discharge

Fine Needle Aspiration Biopsy:
☐ Left ☐ Kidney ☐ Pancreas ☐ Lymph Node site:____
☐ Right ☐ Salivary Gland ☐ Liver ☐ Lung site: ____
☐ Other (specify) ____

Misc/Other: ☐ Common Bile Duct Brushing ☐ Other____

Microbiology Specimen (Sterile, without formalin or preservative)

Specimen Source:

____

☐ Aerobic
☐ Anaerobic Culture
☐ Fungal Culture
☐ Mycobacterial Culture
☐ Other, please specify ____

PHYSICIAN____
ADDRESS ____
PHONE # ____
PHYSICIAN FAX #___________________________________

☐ PHONE REPORT
☐ FAX REPORT

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