

**REQUIRED ITEMS**

1. CBC    2. Clinical Information    3. ICD 10 Codes    4. Face Sheet (Front and Back Copy of the Patient's Insurance Card and Demographic Information)    5. Provider's Signature

**PATIENT INFORMATION**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
 Gender:  Male  Female  Other \_\_\_\_\_  
 DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Patient ID \_\_\_\_\_

**PROVIDER INFORMATION**

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Please Fax Duplicate Report to Provider \_\_\_\_\_ Fax \_\_\_\_\_

**BILLING INFORMATION**

Bill to:  Insurance  Medicare  Referring Facility (Hospital/Client)  Split Billing - Client (TC) and Insurance (PC)  Patient  
 Patient Status:  Inpatient (Hospital)  Outpatient (Hospital)  Non-Hospital  ASC    Prior Authorization # \_\_\_\_\_

**CLINICAL INFORMATION**

Indication(s) for Testing: \_\_\_\_\_  
 ICD-10 Codes: \_\_\_\_\_ Disease:  New Diagnosis  Refractory  Recurrent/Relapsed  Follow-Up

**PRE-OP DIAGNOSIS**

\_\_\_\_\_  
 \_\_\_\_\_

**POST-OP DIAGNOSIS**

\_\_\_\_\_  
 \_\_\_\_\_

**SPECIMEN INFORMATION**

Date Collected \_\_\_\_/\_\_\_\_/\_\_\_\_    SPECIMEN TYPE    SKIN ONLY  
 Time Placed in Formalin (Breast Only) \_\_\_\_:\_\_\_\_  AM  PM     Biopsy     Culture     Punch     Shave  
 Date Retrieved \_\_\_\_/\_\_\_\_/\_\_\_\_     FNA     Submitted Fresh     Curettage     Excision  
 Date Discharged \_\_\_\_/\_\_\_\_/\_\_\_\_     Cytology    Other: \_\_\_\_\_  
 Specimen ID \_\_\_\_\_

**SPECIMEN SITES**

<b>A</b>		<b>H</b>	
<b>B</b>		<b>I</b>	
<b>C</b>		<b>J</b>	
<b>D</b>		<b>K</b>	
<b>E</b>		<b>L</b>	
<b>F</b>		<b>M</b>	
<b>G</b>		<b>N</b>	

LABORATORY USE ONLY