KWB PATHOLOGY ASSOCIATES
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1899 EIDER COURT - P.O. BOX 14389
TALLAHASSEE FL 32317
(850) 878-5143 (888) 878-5143

Facility Name

Facility Address

Facility Phone Number

Provider Full Name

Provider NPI

NONGYN CYTOLOGY REQUEST

LAST NAME FIRST NAME MI

DATE OF BIRTH RACE SEX

SOCIAL SECURITY NUMBER

PATIENT ID#

☐ STAT ☐ DUPLICATE REPORT TO:

BILLING INFORMATION

PATIENT ADDRESS APT. #

CITY STATE ZIP

HOME PHONE# WORK PHONE#

BILL TO (PLEASE CIRCLE)

☐ DOCTOR ☐ PATIENT ☐ CHP ☐ MCR ☐ MCD ☐ OTHER

PRIMARY INSURANCE NAME

ADDRESS

INSURED NAME

ID # GROUP #

SPECIMEN INFORMATION

DATE TAKEN: ____/____/____

GYN: ☐ VAG. ☐ CERVIX ☐ ENDOCX LMP: _____

SPUTUM: ☐ ☐ TZANK SMEAR/SOURCE: _____

BRONCHOSCOPIC:
☐ TRACHEA ☐ RT. BRONCH. ☐ LT. BRONCH.
☐ WASHING ☐ BRUSHING ☐ OTHER

URINE: ☐ VOIDED ☐ CATHETER ☐ BLADDER WASHING
☐ CYSTO ☐ URETER ☐ RIGHT ☐ LEFT

GI: ☐ ESOPHAGUS ☐ COLON ☐ GASTRIC

BODY CAVITY: ☐ PERITONEAL ☐ PLEURAL ☐ PERICARDIAL
☐ PERITONEAL/PELVIC WASHING

BREAST: ☐ RT. NIPPLE DISCHARGE ☐ LT. NIPPLE DISCHARGE

CEREBROSPINAL FLUID: ☐

FINE NEEDLE ASPIRATION: ☐ CYST ☐ SOLID
SITE: _____

OTHER: _____

SPECIMEN SUBMITTED

FLUID: FIXATIVE ADDED _____ ML
☐ 50% ALCOHOL ☐ CYTORICH RED ☐ CYTOLYT

SLIDES: ☐ AIR DRIED # _____ ☐ SPRAY FIXED # _____

CLINICAL INFORMATION

☐ ABNORMAL BLEEDING ☐ MASS - R/O TUMOR
☐ PAINFUL/FREQUENT URINATION ☐ R/O INFECTION
☐ 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

cap ACCREDITED