LMC PATHOLOGY SERVICES
An Aurora Diagnostics Partner

SURGICAL PATHOLOGY / NON-GYN CYTOLOGY REQUISITION

LABEL HERE

CLIENT INFORMATION

Send duplicate report to | Name: | Fax:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	PATIENT ID NUMBER

ADDRESS | ☐ MALE ☐ FEMALE | DATE OF BIRTH ___/___/___

CITY | STATE | ZIP | PHONE ( )

BILLING INFORMATION

PLEASE ATTACH A COPY OF THE PATIENT'S DRIVERS LICENSE - FRONT AND BACK - AND A COPY OF THE PATIENT'S INSURANCE CARD - FRONT AND BACK

Financial and release of information authorization: In consideration for services rendered, I/we hereby assign the benefits due me covering the services provided by Laboratory Medicine Consultants, including major medical benefits. I/we authorize the release of information necessary for insurance purposes. Furthermore, that in consideration of service rendered to the patient, I/we hereby obligate myself/ourselves to assume responsibility for full payment of account.

NAME OF INSURED (SUBSCRIBER) | LAST | FIRST | MI

PATIENT IS: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE ☐ PPO ☐ HMO | ID NUMBER | GROUP NAME/NUMBER

INSURANCE ADDRESS | CITY | STATE/ZIP

SECONDARY INSURANCE/ADDRESS ☐ PPO ☐ HMO | ID NUMBER | GROUP NAME/NUMBER

INSURED PATIENT SIGNATURE FOR FINANCIAL AND RELEASE OF INFORMATION ABN | DATE | PLEASE BILL (CHECK BOX) ☐ DOCTOR/CLIENT ☐ PATIENT ☐ INSURANCE

DIAGNOSIS (SPECIFY ICD 9) 1. | 2. | 3. | 4.

IMPORTANT — MEDICARE PATIENTS: THE ADVANCE BENEFICIARY NOTICE, IF REQUIRED, MUST BE COMPLETED, SIGNED BY THE PATIENT, AND ATTACHED — IMPORTANT

SPECIMEN INFORMATION: COLLECTION DATE ___/___/___ | COLLECTION TIME ___:___ AM PM

SURGICAL / TISSUE BIOPSY - COMPLETE SECTION BELOW

CLINICAL HISTORY	PROCEDURE/HISTORY

SPECIMEN SITE

A. _____ E. _____

B. _____ F. _____

C. _____ G. _____

D. _____ H. _____

FROZEN SECTION ☐ YES ☐ NO **SEND SPECIMEN WITHOUT PRESERVATIVE AND NOTIFY LAB**

NON-GYNECOLOGIC CYTOLOGY

☐ Ascites Fluid

☐ Breast ( ) Left ( ) Right ( ) Cyst Fluid ( ) Nipple Discharge ( ) Solid Mass Aspirate

☐ Bronchial Brushings ( ) Left ( ) Right

☐ Bronchial Washings ( ) Left ( ) Right

☐ Bronchial Lavage ( ) Left ( ) Right

☐ Fine Needle Aspiration, Source: _____

☐ Miscellaneous Body Fluid, Source: _____

☐ Tzanck Smear, Source: _____

☐ Urine ( ) Voided ( ) Catheterized ( ) Indwelling Catheter ( ) Bladder Wash

☐ Pleural Fluid ( ) Left ( ) Right

☐ CSF

☐ Esophageal Brush

☐ Ovarian Cyst Fluid

☐ Pericardial Fluid

☐ Peritoneal Fluid

☐ Pelvic Wash

☐ Sputum

☐ Tracheal Aspirate

OTHER INSTRUCTIONS: _____

LABEL SPECIMEN WITH PATIENT'S NAME AND SPECIMEN SOURCE

3059 S. MARYLAND PARKWAY, #100 • LAS VEGAS, NV 89109 • (TOLL FREE) 877-562-5227 • (P) (702) 732-3441 • (F) (702) 732-2310

WHITE - LAB USE 1 YELLOW - LAB USE 2 PINK - CLIENT COPY