A2Z DIAGNOSTICS
Excellence. It's In Our DNA.

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Suite F19
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P: 732-542-3200
F: 866-495-9427
www.yourgotolab.com

Non GYN Cytology Requisition

Physician Information

Patient Information

Patient Name:_____
(Last Name, First Name)

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:____ /____ /____ Phone#:_____

Gender: ☐ Male ☐ Female SS#:_____

Requesting Physician's Signature

X_____

Collection Information

Collection Date:_____ / _____ / _____ **Time:**_____ **am/pm**

Collection Site: ☐ **Office** ☐ **Home** ☐ **ASC** ☐ **Urgent Care** ☐ **Hospital**

Billing Information (Please attach copies of all cards, front and back)

PRIMARY ☐ **Billing Information Attached**
☐ **Medicare** ☐ **Medicaid** ☐ **Other Insurance** ☐ **Self Pay** ☐ **Bill Ordering Physician**
Insurance Carrier:_____ Policy/ID #:_____ Group #:_____

SECONDARY
☐ **Medicare** ☐ **Medicaid** ☐ **Other Insurance** ☐ **Self Pay** ☐ **Bill Ordering Physician** (no ins. info needed)

ICD-10 CODE(S):_____

Clinical Information

_____

_____

_____

Non-GYN Cytology/Fluids and Brushings

☐ **URINE**: ☐ Voided ☐ Cysto. ☐ Cath. ☐ Other:_____

☐ **GASTRIC BRUSH** ☐ **ESOPHAGEAL BRUSH**

☐ **OTHER:**_____

Aspiration Cytology

☐ **BREAST (A)**: ☐ Right ☐ Left ☐ Cyst ☐ Mass/Lump (____ o'clock)

☐ **BREAST (B)**: ☐ Right ☐ Left ☐ Cyst ☐ Mass/Lump (____ o'clock)

☐ **NECK MASS**: ☐ Right ☐ Left ☐ **LYMPH NODE:**_____

Thyroid Fine Needle Aspiration Cytology

THYROID (A): ☐ Right Lobe ☐ Left Lobe ☐ Isthmus ☐ Upper Pole ☐ Mid Lobe ☐ Lower Pole

THYROID (B): ☐ Right Lobe ☐ Left Lobe ☐ Isthmus ☐ Upper Pole ☐ Mid Lobe ☐ Lower Pole

Specimen A Description

VOLUME: ☐ Scant ☐ Less than 1 cc ☐ _____cc

COLOR: ☐ Bloody/Red ☐ Amber ☐ Yellow ☐ Other:_____

CLARITY: ☐ Clear ☐ Opaque ☐ Cloudy ☐ Other:_____

NUMBER OF PASSES: ☐ One ☐ Two ☐ Three ☐ Other:_____

SLIDES: # Air dried:_____ # Fixed:_____ # vial(s)/containers:_____

Specimen B Description

VOLUME: ☐ Scant ☐ Less than 1 cc ☐ _____cc

COLOR: ☐ Bloody/Red ☐ Amber ☐ Yellow ☐ Other:_____

CLARITY: ☐ Clear ☐ Opaque ☐ Cloudy ☐ Other:_____

NUMBER OF PASSES: ☐ One ☐ Two ☐ Three ☐ Other:_____

SLIDES: # Air dried:_____ # Fixed:_____ # vial(s)/containers:_____

Patient Consent: I authorize payment to be paid to A2Z Diagnostics, LLC shown above for laboratory testing benefits otherwise payable to me. I understand I am financially responsible to A2Z Diagnostics, LLC for charges not paid or payable under my insurance program attached. I understand that my insurance may not be able to honor this request. If they cannot, they will pay the benefits directly to me as the insured and will direct the payment to A2Z Diagnostics, LLC.

Patient Signature: _____

A2Z DIAGNOSTICS Excellence. It's In Our DNA.

A **Name:**_____ **Site:**_____

A2Z DIAGNOSTICS Excellence. It's In Our DNA.

OTHER **Name:**_____ **Site:**_____

A2Z DIAGNOSTICS Excellence. It's In Our DNA.

OTHER **Name:**_____ **Site:**_____

A2Z DIAGNOSTICS Excellence. It's In Our DNA.

B **Name:**_____ **Site:**_____

A2Z DIAGNOSTICS Excellence. It's In Our DNA.

OTHER **Name:**_____ **Site:**_____

A2Z DIAGNOSTICS Excellence. It's In Our DNA.

OTHER **Name:**_____ **Site:**_____