

CMC LABORATORY LABEL



100 McGregor St  
Manchester, NH 03102  
603-663-8031

**SURGICAL PATHOLOGY / NON-GYN CYTOLOGY REQUISITION**

Patient Name\* \_\_\_\_\_ Sex\* \_\_\_\_ DOB\* \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Requesting Doctor\* \_\_\_\_\_ Referring/Attending Doctor \_\_\_\_\_

Copies to: (Must provide complete name and address) \_\_\_\_\_

Fax: \_\_\_\_\_ Call: \_\_\_\_\_

Primary Insurance\* \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurer Address\* \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ State \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ State \_\_\_\_\_

<b>Specimen Information *</b>	<b>Collection Date:</b>	<b>Collection Time:</b>	<b>Received Date:</b>	<b>ICD-9 Code (Required)</b>
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- Surgical Pathology Specimen       Frozen Section       Non-Gyn Cytology

**Specimen Source(s):\***

A.	F.
B.	G.
C.	H.
D.	I.
E.	J.

**Non-GYN Specimen Source\***

<p><b>Fine Needle Aspiration</b></p> <p><input type="checkbox"/> Specify site: _____</p> <p><b>Breast Cytology</b></p> <p><input type="checkbox"/> Nipple Discharge Specify: L ___ R ___</p> <p><input type="checkbox"/> Other (specify)</p>	<p><b>Body Fluid</b></p> <p><input type="checkbox"/> Ascites/Peritoneal</p> <p><input type="checkbox"/> Pleural L ___ R ___</p> <p><input type="checkbox"/> Joint <input type="checkbox"/> Cyst (specify) _____</p> <p><input type="checkbox"/> CSF <input type="checkbox"/> Cul-De-Sac</p> <p><input type="checkbox"/> Other (specify)</p>	<p><b>Respiratory</b></p> <p><input type="checkbox"/> Sputum</p> <p><input type="checkbox"/> Bronchial Brush L ___ R ___</p> <p><input type="checkbox"/> Bronchial Wash L ___ R ___</p> <p><input type="checkbox"/> Bronchoalveolar Lavage Specify: L ___ R ___</p> <p><input type="checkbox"/> Silver Stain <input type="checkbox"/> Oil Red O (Pneumocystis)</p>	<p><b>Gastro-Intestinal</b></p> <p><input type="checkbox"/> Esophageal Brush</p> <p><input type="checkbox"/> Colonic Brush</p> <p><input type="checkbox"/> Duodenal Brush</p> <p><input type="checkbox"/> Pancreatic Brush</p> <p><input type="checkbox"/> Other</p>	<p><b>Urinary</b></p> <p><input type="checkbox"/> Urine Voided ___ Cath ___</p> <p><input type="checkbox"/> Bladder Wash</p> <p><input type="checkbox"/> Renal Brushing Specify: _____</p> <p><input type="checkbox"/> Urine from Ureter Specify: L ___ R ___</p> <p><input type="checkbox"/> Urine special tests Specify: _____</p>
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\*\*Fields Marked with the Asterisk are REQUIRED. Specimen may not be processed if not filled in\*\*

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**Patient Clinical History/Pre-Op Diagnosis:**

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**Previous abnormal pathology diagnosis (please provide date):**

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