The Area Above This Line Is For Lab Use Only

X·Cell Laboratories of Western New York, Inc.
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Date Collected

Date Received (Lab Use)

Ordering Physician / Client

Authorized Signature (required)

PLEASE PRINT ALL INFORMATION CLEARLY

Patient Name	Last	First
Address		
City State Zip		
D.O.B.		Sex		Phone	

ICD-10 Code (Mandatory)	ICD-10 Code	ICD-10 Code	ICD-10 Code

BILLING

☐ Insurance ☐ Patient ☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

SECONDARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

COPY OF REPORT TO: (**FAX NUMBER MUST BE PROVIDED**)

NAME	FAX #
NAME	FAX #
NAME	FAX #

Please label all specimens with the patient's full name and date of birth. Provide patient's clinical history and other relevant information as appropriate. This is a requirement of the NYSDOH.

Special Instructions / Comments / Clinical history:

INTRAOPERATIVE CONSULTATION *

☐ Frozen section ☐ Table diagnosis

* For intraoperative consulation, please notify the laboratory at least 30 minutes before specimen will be taken. A fresh tissue specimen should be submitted with NO added fixative or fluid.

TISSUE PATHOLOGY (BIOPSY) PLEASE INDICATE SPECIMEN TYPE (EXACT ANATOMIC LOCATIONS)

A	**E**	**I**
B	**F**	**J**
C	**G**	**K**
D	**H**	**L**

NON-GYN CYTOLOGY

A ☐ Breast FNA ☐ Left ☐ Right ☐ Thyroid FNA ☐ Left ☐ Right

Specimen Type / Location:

B ☐ Breast FNA ☐ Left ☐ Right ☐ Thyroid FNA ☐ Left ☐ Right

Specimen Type / Location:

☐ FNA, other

Specimen Type / Location:

☐ Urine cytology

☐ Washings	☐ Brushings	☐ Direct smear (s)	Additional tests:
Source:	Source:	Source:	