Mercy Lab

Non-Gynecological Cytology Requisition Form

phone 800.755.7886
fax 833.752.3788

COLLECTION:

Date _____ Time _____

Patient

Patient Last Name	Legal First Name	MI

Birthdate *(MO/DAY/YR)*	Age	Sex	Social Security #

Physician

Physician *(print)* Last Name	First Name	Phone # / Fax #	☐ Copy to Dr. _____ ☐ Call to #_____ ☐ Fax to #_____
Physician Address			

Billing — Insurance *(attach copy of insurance card OR complete all information below)*

Insurance _____ Employer _____

Member I.D.# _____ Group #_____ SS # _____

Member Name _____ ☐ Self ☐ Spouse ☐ Child

Address _____

Secondary Ins. _____ I.D.# _____ Group # _____

Symptom or Diagnosis (ICD-10) Code *(required for each test ordered)*

Non-Gynecological Cytology

Source/Procedure

☐	Fine needle aspiration biopsy (specify site):	☐	Bronchial Brushing ☐ R ☐ L
☐	Pleural Fluid	☐	Bronchial Washing ☐ R ☐ L
☐	Peritoneal Fluid	☐	Biliary
☐	Pericardial Fluid	☐	Voided Urine
☐	Cerebrospinal Fluid	☐	Instrumented Urine
☐	Bronchoalveolar lavage (specify site):	☐	Urinary Tract Washing (specify site):
☐	Other:		

Specify fixative:

☐ CytoLyt ☐ Alcohol ☐ Other_____

Clinical History/Information:

Clinical Diagnosis:

Special Instructions: