SBMF
South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

Client Name: _____

✓ Physician's Last Name, First Name	✓ Physician's Last Name, First Name
[ ] _____	[ ] _____
[ ] _____	[ ] _____
[ ] _____	[ ] _____
[ ] _____	[ ] _____
[ ] _____	[ ] _____
[ ] _____	[ ] _____

Signature of Ordering Provider and Date

_____

(Signature must be dated, legible, and include first and last name)

Printed Name _____

PATIENT INFORMATION – Please PRINT or place label here

Name _____
Last First MI

SS# _____

DOB _____ SEX _____
MO / DAY / YEAR

BILLING – PLEASE INCLUDE FACESHEET
IF NO BILLING INFORMATION IS PROVIDED YOUR ACCOUNT WILL BE BILLED.

- ☐ PRIOR AUTHORIZATION
- ☐ PHYSICIAN / ACCOUNT
- ☐ PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION ATTACHED
- ☐ BCCP, Alpha ID# _____

SBMF USE ONLY
Accession #/Label

SPECIMEN COLLECTION

Date and Time _____ ☐ AM ☐ PM

Collector's Initials: _____

PRIORITY ☐ **Routine** ☐ **Phone** ☐ **STAT** ☐ **Fax#** _____

Performing Radiologist/Physician: _____

Ordering Physician: _____

Copy To: _____

Copy To: _____

38560: NON-GYNECOLOGIC CYTOPATHOLOGY

Fine Needle Aspiration

- ☐ Breast Lesion ☐ L ☐ R
- ☐ Lymph Node Location _____
- ☐ Lung ☐ L ☐ R
- ☐ Salivary Gland ☐ L ☐ R
  - Specify _____
- ☐ Other FNA ☐ L ☐ R
  - Specify: _____
- ☐ Thyroid #1 _____ ☐ L ☐ R
- ☐ Thyroid #2 _____ ☐ L ☐ R
- ☐ w/Reflex to ThyroSeq

Fluids

- ☐ Cerebrospinal Fluid
- ☐ Pleural Fluid
  - Source: ☐ L ☐ R ☐ Bilateral
- ☐ Peritoneal Fluid
- ☐ Pelvic Wash
- ☐ Urine
  - Source: ☐ Cath/Cysto ☐ Ureter ☐ Voided ☐ Other _____
- ☐ Breast Discharge
- ☐ Other Specify: _____

CLINICAL HISTORY REQUIRED

Please specify patient history and clinical/radiological finding.

FOR LABORATORY USE ONLY

_____ Collected Smears, total _____

_____ Received Smears, total _____

☐ Fixed _____ ☐ Unfixed _____

Wash ☐ yes ☐ no ☐ ThyroSeq Vial

Received # _____ (CC) _____ Color

Fluid: ☐ Fixed ☐ Unfixed

Received # _____ (CC) _____ Color

Fluid: ☐ Fixed ☐ Unfixed