PRECISION PATHOLOGY®
Quality diagnostics for optimum patient care

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NOTE: CA TITLE 17 (SEC. 1050 REQUIRES THE PHYSICIAN TO PROVIDE PATIENT'S DOB, SOURCE OF SPECIMEN, LMP, HISTORY, THERAPY, AND SLIDE/VIAL LABELED APPROPRIATELY - TWO (2) IDENTIFIERS.

Date Collected:	Patient Name:		Birth Date:	Sex:
Street Address/Apt #:		City:	State:	Zip:
Responsible Party Phone #:	Social Security No.:	MRN #:	Physician Performing Procedure:	

Type of Billing: ☐ Patient ☐ Insurance ☐ Medicare ☐ Medi-Cal ☐ Client ☐ Slide Prep Only
(Please attach a copy of the front and back of the patients insurance card.)

Diagnosis Codes:

CLINICAL HISTORY

COPY TO PHYSICIAN(S)

CYTOLOGY SPECIMEN(S)

Cytology Specimen: _____

☐ Ascites/Paracentesis
☐ Breast Discharge/Fluid
☐ Bronchial Brushings
☐ Bronchial Washings
☐ CSF
☐ Pleural Fluid/Thoracentesis
☐ Sputum
☐ Urine
☐ FNA: _____

HISTOLOGY SPECIMEN(S)

Time Placed in Formalin: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

COMMENTS

SERVICE(S) PERFORMED
(FOR LAB USE ONLY)

PQ1234567

TISSUES
☐ 88300 PATH LEVEL 1 X ___
☐ 88302 PATH LEVEL 2 X ___
☐ 88304 PATH LEVEL 3 X ___
☐ 88305 PATH LEVEL 4 X ___
☐ 88307 PATH LEVEL 5 X ___
☐ 88309 PATH LEVEL 6 X ___
☐ 88329 CONSULT DURING SURG X ___
☐ 88331 FROZEN SECTION X ___
☐ 88332 ADDL FROZEN X ___
☐ 88361 MORPH. TUMOR EXAM X ___
☐ 88189 FLOW CYTOMETRY MARKER X ___

STAINS
☐ 88311 DECAL X ___
☐ 88312 STAIN GRP I X ___
☐ 88313 STAIN GRP II X ___
☐ 88342 IMMUNOHISTO/EA ANTIGEN X ___
☐ 88309 IN SITU HYBRIDIZATION X ___

☐ OTHER:
☐ 99000 TRANSPORT CHARGE X ___

Pt. Name:_____ Source:_____ PQ1234567	Pt. Name:_____ Source:_____ PQ1234567	Pt. Name:_____ Source:_____ PQ1234567	Pt. Name:_____ Source:_____ PQ1234567