central peninsula pathology

Central Peninsula Hospital
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ALL FIELDS ARE REQUIRED
Please include Demographic Sheet and Patient History.
Please label your specimens.

Patient Information		
PATIENT LAST NAME	FIRST NAME	M.I.
PATIENT DOB	MRN#	SEX

Specimen Information		
COLLECTION DATE	TIME	ICD 10 CODE(S)

Clinical History/Procedure:	

Authorizing Provider: (Name/Address)	
Ordering Provider: (Name/Address)	
Copy Report To:	

Physician Signature: _____ DATE: _____

MUST BE SIGNED BY PHYSICIAN (Unless separate signed physician order or physician note accompanies this requisition).

HISTOLOGY (TISSUE SPECIMENS)

SPECIMEN

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

ALL SPECIMENS: Time Tissue Removed: _____ Time Placed in Formalin: _____

NON-GYN CYTOLOGY

☐ **FLUID**, Source/Laterality: _____

☐ **FNA**, Source/Laterality: _____

☐ **RESPIRATORY CYTOLOGY:** ☐BAL ☐ Brushing ☐ Washing ☐ Sputum

☐ **URINE CYTOLOGY:** ☐ Voided ☐ Catheterized ☐ Bladder Washing ☐ Barbotage

☐ **NIPPLE DISCHARGE:** ☐ Right ☐ Left