PATHOLOGY & CYTOLOGY LABORATORIES
CHIPPS, CAFFREY & DUBILIER, P.S.C.

290 BIG RUN ROAD
LEXINGTON, KY 40503-2903
(859) 278-9513
WATS 1-800-264-0514
FAX 1-859-277-6063

ACCESSION NUMBER

BILLING INFORMATION
(MUST BE CHECKED)
☐ ACCOUNT
☐ PATIENT
☐ INSURANCE
☐ IN-PT. ☐ OUT-PT.
☐ _____

USE ADDRESSOGRAM STAMP HERE

PATIENT INFORMATION (PLEASE PRINT)

SOCIAL SECURITY NO. REQUIRED

PATIENT NAME: LAST	FIRST	MI	CLIENT REF #	SEX ☐ M ☐ F	DATE OF BIRTH	DATE COLLECTED	REQUESTING PHYSICIAN (REQUIRED)

ADDITIONAL COPY OF REPORT TO: (ADDRESS REQUIRED) ADDRESS CITY STATE ZIP

PLEASE COMPLETE BILLING & INSURANCE INFORMATION - ATTACH COPY OF INS. CARD OR DEMOGRAPHICS SHEET

ADDRESS REQUIRED FOR ALL PATIENTS

ADDRESS (INCLUDE APT #) APT. #

CITY STATE ZIP code

TELEPHONE NO. HOME TELEPHONE NO. WORK

RESPONSIBLE PARTY/POLICYHOLDER (IF OTHER THAN PATIENT)

ADDRESS (INCLUDE APT #)

CITY STATE ZIP CODE

☐ BC/BS ☐ BGFH ☐ HUMANA ☐ AETNA ☐ UHC KY ☐ UHC OTHER

POLICY ID#

GROUP INSURANCE NAME

INS. ADDRESS

CITY/STATE ZIP

☐ MEDICARE ID#
ABN REQUIRED

☐ MEDICAID ID#
☐ MCO ID#

Postoperative diagnosis or chief reason for surgery:
ICD-10 codes required

NEEDLE LOCALIZATION BREAST SPECIMENS: Attach copy of mammogram report and specimen Mammogram, if possible. Does the mammogram show calcifications? Yes ☐ No ☐

Have there been any previous tissues or smears related to this specimen sent to another laboratory? If so, please indicate laboratory and send copies of the reports.
☐ YES, DATE IF KNOWN_____ ☐ NO ☐ DON'T KNOW

SPECIMEN TYPE	LEFT	RIGHT	SPECIMENS SUBMITTED:	TIME EXCISED	TIME INTO FIXATIVE
☐ LUMPECTOMY	☐	☐			
☐ SENTINEL NODE	☐	☐			
☐ SIMPLE MASTECTOMY	☐	☐			
☐ NON SENTINEL NODE	☐	☐			
☐ MOD. RAD. MASTECTOMY	☐	☐			
☐ NEEDLE CORE	☐	☐			
☐ FNA BREAST	☐	☐			
☐ OTHER	☐	☐			

DO NOT WRITE BELOW HERE - FOR LABORATORY USE ONLY

88305	88311	88341	88329	88170	3260F	Specimen Preparation
88307	88312	88342	88331	88172	3394F	☐ Thin Prep
88309		88360	88332	88173		☐ Cytospin
			88337	88177		☐ Smears
			88338			☐ Cell Block
						☐ Other

TISSUE QA 1 2 3 4 5

Form #601 9/15

FOR BREAST SPECIMENS OR BREAST CANCER SPECIMENS ONLY

PCI COPY