



311 West 8th Street Rome, GA 30165


Collection Date	Clinician	Additional Clinician (s)	Office Location
-----------------	-----------	--------------------------	-----------------

P A T I E N T	*Name (Last) _____ (First) _____ (MI) _____ PT ID # _____
	*SSN _____ *Date of Birth _____ *Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	Patient Address _____ Phone _____
	City _____ State _____ Zip _____

CLINICAL DATA

Clinical History: _____

Mark the site(s) #1 and #2 biopsied on the image

Right

Left

CYTOLOGY SPECIMEN #1

CYTOLOGY SPECIMEN #2

Site: _____ <input type="checkbox"/> CytoLyt® # of Slides: _____ <input type="checkbox"/> REFLEX TO miRInform® Thyroid Panel on Indeterminate CytoLOGY (BRAF (1), KRAS (7), HRAS (3), NRAS (3), RET/PTC1, RET/PTC3, and PAX8/PPARg) **Requires sample in RNARetain vial	Site: _____ <input type="checkbox"/> CytoLyt® # of Slides: _____ <input type="checkbox"/> REFLEX TO miRInform® Thyroid Panel on Indeterminate CytoLOGY (BRAF (1), KRAS (7), HRAS (3), NRAS (3), RET/PTC1, RET/PTC3, and PAX8/PPARg) **Requires sample in RNARetain vial
---	---

ULTRASOUND FINDINGS SITE #1

ULTRASOUND FINDINGS SITE #2

<input type="checkbox"/> Hypoechoic <input type="checkbox"/> Irregular Border <input type="checkbox"/> Microcalcifications <input type="checkbox"/> Intranodular Vascular Pattern <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Size _____	<input type="checkbox"/> Hypoechoic <input type="checkbox"/> Irregular Border <input type="checkbox"/> Microcalcifications <input type="checkbox"/> Intranodular Vascular Pattern <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Size _____
---	---

DX CODES: _____

PRIMARY INSURANCE AND SECONDARY INSURANCE

****PLEASE ATTACH A FACE SHEET AND A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD ****

F O R S E P U S E	88300 _____ CPT Level I	88311 _____ Decalcification	88305 _____ Cell Block
	88302 _____ CPT Level II	88312 _____ Organism Stain	88104 _____ Smear, non GYN
	88304 _____ CPT Level III	88313 _____ Other Special Stain	88112 _____ ThinPrep non-GYN
	88305 _____ CPT Level IV	88342 _____ IHC Stain Manual	88173 _____ Fine Needle Aspirate Interp
	88307 _____ CPT Level V	88360 _____ IHC Manual Qnt or Semiqnt	88160 _____ Cytosmear TouchPrep SI
	88309 _____ CPT Level VI	88361 _____ IHC Stain VIAS	88161 _____ Cytosmear TouchPrep PSI
	88321 _____ Consult on Ref Slides	85060 _____ Peripheral Smear Path Interp	

Additional testing may be performed if determined medically necessary to render a diagnosis in the opinion of the reviewing pathologist.

**C
A
S
E
#**