SEE COLLECTION INSTRUCTIONS ON REVERSE

UCSF Health

Fine Needle Aspiration Clinic and Cytopathology
Department of Pathology
1825 Fourth Street, L2190
San Francisco, CA 94143
Tel (415) 885-7301 Fax (415) 353-7676 Hours:
9:00AM to 5:00PM Monday through Friday

MRN# **C:**

Patient Name (Last, First, M):

Date of Birth: Age: Sex:

SPECIMEN DATE:

NON-GYNECOLOGIC CYTOLOGY REQUEST FORM

REQUESTOR INFORMATION

COMPLETE ALL ITEMS – PRINT LEGIBLY

Ordering Provider _____ UCSF Provider # ___ ___ ___ ___ ___ (Required) Clinic Name: _____

Provider is a(n): ☐ Attending ☐ Resident/Fellow *(attending info. req'd.)* ☐ Allied Health Practitioner *(Incl. attending info. if req'd.)*

Attending Physician _____ (Print Name) UCSF Provider # ___ ___ ___ ___ ___ (Required) Phone/Pager: _____

Copy to: _____ (Print Name) Address _____

MEDICAL NECESSITY and ICD CODES – REQUIRED

ICD code(s) is/are necessary to indicate medical necessity and for billing purposes. If a carrier might not pay for a test, inform the patient and have them sign Advanced Beneficiary Notice (ABN) to be attached to requisition, indicating responsibility to pay in case of carrier denial of payment.

CA STATE REG. REQUIRE ORDERING PROVIDER TO STATE SOURCE OF SPECIMEN, AGE, PERTINENT HISTORY AND SLIDE ID.

ICD Code	CLINICAL HISTORY AND PRESENTATION

Body Cavities
- ☐ Pleural
- ☐ Pericardial
- ☐ Ascitic
- ☐ Peritoneal Wash
- ☐ Pelvic Wash
- ☐ Diaphragm

URINARY
- ☐ Urine, Voided
- ☐ Urine, Cath
- ☐ Bladder Wash
- ☐ Ureteral
- ☐ Urethral
- ☐ Neo Bladder

GI
- ☐ Esophageal
- ☐ Gastric
- ☐ Bile Duct
- ☐ Duodenal
- ☐ Colonic

Respiratory
- ☐ Sputum
- ☐ Induced Sputum
- ☐ Bronchial Brush
- ☐ Bronchial Wash

CNS
- ☐ CSF
- ☐ Ventrical
- ☐ Cyst

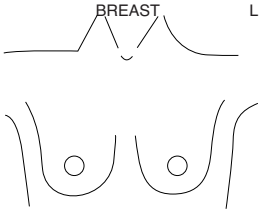
Other
- ☐ Nipple Discharge
- ☐ _____

Fine Needle Aspiration
- ☐ Lung
- ☐ Thyroid
- ☐ Breast
- ☐ Salivary Gland
- ☐ Liver
- ☐ Pancreas
- ☐ Lymph Node
- ☐ Soft Tissue / Bone
- ☐ Other: Specify _____

To Request Mt. Zion FNA: see back for instructions.

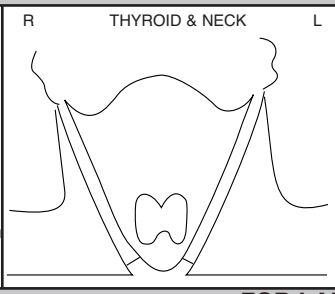
☐ **Concurrent Tissue** ☐ **Radiation Therapy** ☐ **Chemotherapy** ☐ **Hormonal Therapy**

R BREAST L

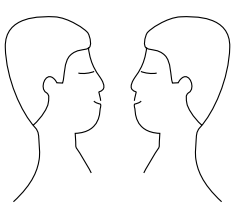


Breast Distance from nipple _____ cm
_____ o'clock position
Size of Mass _____ cm

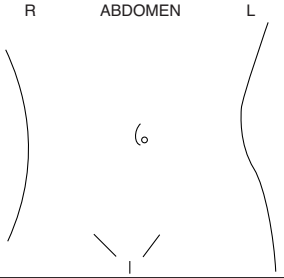
R THYROID & NECK L



R L



R ABDOMEN L



PHYSICIAN'S OPTIONAL DRAWING

FOR LABORATORY USE ONLY

Specimen Description:_____cc.
Prepared by:_____

- ☐ Clear ☐ Cloudy ☐ Partic.
- ☐ Bloody ☐ Mucoid ☐ Clotted
- ☐ Yellow ☐ Fresh ☐ Refrigerated

Number of Slides:
Direct: Pap_____ MGG_____ Other_____
Concentrated: ThinPrep_____ Spin_____ Filter_____
Special Stain(s)_____Cell Block_____

COMMENTS

Two patient identifiers and FNA site checked by: _____

Verbal consent obtained and brochure provided: _____

Comment by Aspirator: _____

Rapid Interpretation/Adequacy: _____

Aspirator _____ M.D. ID#_____

NON-GYNECOLOGIC CYTOLOGY REQUEST FORM

MZ-422070-008 (Rev. 04/19) ORIGINAL - MEDICAL RECORD COPY CANARY - PATHOLOGY DEPT. COPY

DIRECTIONS FOR COLLECTION OF SPECIMENS FOR CYTOLOGY

In compliance with National Patient Safety standards, please label all specimens (containers and slides) with 2 patient identifiers. Please include the patient's first and last names and one of the following: Medical Record Number or date of birth.

FINE NEEDLE ASPIRATION:

1) FNA biopsy inquiry call (415) 885-7301, 9:00 AM to 5:00 PM Monday through Friday.
2) The Mission Bay FNA Clinic is located at 1825 Fourth Street, on the 2nd Floor.
3) The Mount Zion FNA Clinic is located in the Helen Diller Cancer Center (H) Building at 1600 Divisadero Street, on the 4th Floor. After entering the building, use the elevators to the left.