Biopsy and Non-Gynecological Cytology Request Form

Last Name _____ First Name _____

SS# _____
(Medical Record Requirement)

Date of Birth _____ Age _____ Sex _____ Daytime Phone # _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

DATE: _____

REQUESTING PHYSICIAN _____

PRACTICE LOCATION _____
(Practices with multiple offices only)

Patient history and source of specimen:

_____

_____

_____

ICD-9 CODE: _____

SPECIMEN CONTAINER MUST BE LABELED.
Patient name and specimen source required.

1.) Attach copy of patient insurance card; OR
2.) Attach copy of office patient data; OR
3.) Complete the following. . .

Insurance Company Name: _____ Claims Mailing Address: _____

Patient ID#: _____ _____

Employer or Group: _____ _____

Insured Name: _____ _____

acla
ANATOMIC & CLINICAL
LABORATORY ASSOCIATES, P.C.

MID-STATE MEDICAL CENTER 2010 CHURCH ST., STE. 615 NASHVILLE, TN 37203
TEL: 615 284 7956 **FAX:** 615 284 4368

All services performed in Baptist Hospital Laboratory, Nashville, Tennessee | Barrett D. Brantley, M.D., Director