



South Bend Medical Foundation  
3355 Douglas Road, South Bend, IN 46635

NON-GYNECOLOGIC RESPIRATORY CYTOPATHOLOGY REQUISITION

Client Name: \_\_\_\_\_

<p><b>Signature of Ordering Provider and Date</b></p> <p>_____ (Signature must be dated, legible, and include first and last name)</p> <p>Printed Name _____</p>	<p><b>BILLING</b></p> <p>PLEASE INCLUDE FACESHEET IF NO BILLING INFORMATION IS PROVIDED YOUR ACCOUNT WILL BE BILLED.</p>	<p><b>SBMF USE ONLY</b></p> <p>Accession #/Label</p>
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<p><b>PATIENT INFORMATION – Please PRINT or place label here</b></p> <p>Name _____ Last First MI</p> <p>SS# _____</p> <p>DOB _____ SEX _____ MO / DAY / YEAR</p>	<p><b>SPECIMEN COLLECTION</b></p> <p>Date and Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM</p> <p>Collector's Initials: _____</p> <p><b>PRIORITY</b> <input type="checkbox"/> Routine <input type="checkbox"/> Phone <input type="checkbox"/> STAT <input type="checkbox"/> Fax# _____</p>
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<p>Performing Radiologist/Physician: _____</p> <p>Ordering Physician: _____</p>	<p>Copy To: _____</p> <p>Copy To: _____</p>
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**38560: NON-GYN RESPIRATORY CYTOPATHOLOGY**

Bronchial Specimens NG	EBUS Specimens FNA <small>(prioritize sample for cell block)</small>	Navigational/Monarch Specimens FNA
<p><b>See PREPARATION GUIDELINES Below</b></p> <p><input type="checkbox"/> Bronchial Washing <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> Bronchial Washing with Pneumocystis <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> BAL <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> BAL with Pneumocystis <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> BAL for cultures (split specimen) <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> BAL for Lipid (requires unfixed sample) <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> BAL for Iron <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> Bronchial Brushing <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>_____ # fixed smears or <input type="checkbox"/> Brush only</p> <p><input type="checkbox"/> Received by Lab</p> <p>Received _____ total slides _____ fixed _____ unfixed</p> <p>Received # _____ (CC) _____ Color</p> <p>Fluid: <input type="checkbox"/> Fixed <input type="checkbox"/> Unfixed</p> <p>Received # _____ (CC) _____ Color</p> <p>Fluid: <input type="checkbox"/> Fixed _____ <input type="checkbox"/> Unfixed</p>	<p><input type="checkbox"/> Lymph Node #1 Location _____</p> <p>_____ total # of smears _____ # fixed smears _____ # air-dried smears</p> <p>Washing for cell block <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Received by Lab</p> <p><input type="checkbox"/> Lymph Node #2 Location _____</p> <p>_____ total # of smears _____ # fixed smears _____ # air-dried smears</p> <p>Washing for cell block <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Received by Lab</p> <p><input type="checkbox"/> Lymph Node #3 Location _____</p> <p>_____ total # of smears _____ # fixed smears _____ # air-dried smears</p> <p>Washing for cell block <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Received by Lab</p> <p><input type="checkbox"/> Lymph Node #4 Location _____</p> <p>_____ total # of smears _____ # fixed smears _____ # air-dried smears</p> <p>Washing for cell block <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Received by Lab</p>	<p>Location #1 _____ Needle _____ Brush _____</p> <p>_____ total # of smears _____ # fixed smears _____ # air-dried smears</p> <p>Washing: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Received by Lab</p> <p>Location #2 _____ Needle _____ Brush _____</p> <p>_____ total # of smears _____ # fixed smears _____ # air-dried smears</p> <p>Washing: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Received by Lab</p>

	<p><b>PREPARATION GUIDELINES</b></p>
	<ul style="list-style-type: none"> <li>• Fixation <ul style="list-style-type: none"> <li>○ Prepared smears – immediate fixation in 95% Ethanol.</li> <li>○ Fluid and FNA needle rinse/residue – 30 ml in cytology fixative.</li> </ul> </li> <li>• Large volume specimens (&gt;30 ml) – submit 30 ml in cytology fixative and the remainder in the original container.</li> <li>• <u>Use Cytolyt fixative only</u> for Non-Gyn Specimens</li> </ul> <p>Label All Smears and Specimen Containers with Patient Name, DOB and Source.</p>

<p><b>CLINICAL HISTORY REQUIRED</b></p>	
<p>Please specify patient history and clinical/radiological finding</p> <p>_____</p> <p>_____</p> <p>_____</p>	