The Area Above This Line Is For Lab Use Only

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Date Collected *

Time Collected *

* Per updated CAP guidelines, it is imperative that date and time of collection is provided

Ordering Physician / Client

Authorized Signature (required)

PLEASE PRINT ALL INFORMATION CLEARLY

Patient Name	Last	First
Address		
City State Zip		
D.O.B.		Sex		Phone	

ICD-10 Code (Mandatory)	ICD-10 Code	ICD-10 Code	ICD-10 Code

BILLING

☐ Insurance ☐ Patient ☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

SECONDARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

COPY OF REPORT TO: (**FAX NUMBER MUST BE PROVIDED**)

NAME	FAX #
NAME	FAX #
NAME	FAX #

Please label all specimens with the patient's full name and date of birth. Provide patient's clinical history and other relevant information as appropriate. This is a requirement of the NYSDOH.

Special Instructions / Comments / Clinical history:

INTRAOPERATIVE CONSULTATION *

☐ Frozen section ☐ Table diagnosis

* For intraoperative consulation, please notify the laboratory at least 30 minutes before specimen will be taken. A fresh tissue specimen should be submitted with NO added fixative or fluid.

TISSUE PATHOLOGY (BIOPSY) PLEASE INDICATE SPECIMEN TYPE (EXACT ANATOMIC LOCATIONS)

A	**D**	**G**
B	**E**	**H**
C	**F**	**I**

NON-GYN CYTOLOGY / FINE NEEDLE ASPIRATE

A Specimen Type / Location:	**B** Specimen Type / Location:	**C** Specimen Type / Location:

STOOL TESTING

☐ Clostridioides difficile *

☐ Enteric bacterial panel *

☐ Enteric parasite panel *

* Please submit sample in a sterile cup

MICROBIOLOGY

☐ Aerobic culture

☐ Anaerobic culture

☐ Fungal culture

Source of culture: _____

ADDITONAL TESTS

☐ Respiratory virus panel *

* Please submit a nasal swab using UTM media; panel includes RSV, Influenza A, Influenza B, & SARS-CoV-2