

**Required Information is Highlighted**

CellNetix Pathology & Laboratories



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| Patient Information                   |                                   |  |   | Specimen Information  |                 |      |
|---------------------------------------|-----------------------------------|--|---|---|-----------------|------|
| PATIENT LAST NAME                     | FIRST                             | M.I.   | BIRTH SEX<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X | GENDER ID<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X | COLLECTION DATE | TIME |
| PATIENT D.O.B.                        | PATIENT SOCIAL SECURITY NUMBER    | MRN  | RACE/ETHNICITY  |   | ICD-10 CODE(S)  |      |
| STREET ADDRESS                        |                                   |  |   |   |                 |      |
| CITY                                  | STATE                             | ZIP  | PHONE   |   |                 |      |
| Billing Information                   |                                   |  |   |   |                 |      |
| INSURANCE COMPANY NAME AND ADDRESS    |                                   |  |   |   |                 |      |
| CITY                                  | STATE                             | ZIP  |   |   |                 |      |
| INSURANCE/SUBSCRIBER ID#              | SUBSCRIBER NAME/RESPONSIBLE PARTY |  |   |   |                 |      |
| INSURANCE/GROUP#                      | MEDICARE#                         | <input type="checkbox"/> PRIMARY<br><input type="checkbox"/> SECONDARY |   |   |                 |      |
| SECONDARY                             | MEDICAID (coupon attached)        |  |   |   |                 |      |
| <input type="checkbox"/> NO INSURANCE |                                   | WORKER'S COMP  | <input type="checkbox"/> YES <input type="checkbox"/> NO                                      |   |                 |      |
| INTERNAL USE ONLY                     |                                   |  |   |   |                 |      |
| Referring MDs                         |                                   |  |   |   |                 |      |
|                                       |                                   |  |   |   |                 |      |
| CC report to:                         |                                   |  | First and Last Names  |   |                 |      |

| FINE NEEDLE ASPIRATION   |  |
|--|--|
| <p><b>SPECIMEN SOURCE (List each biopsy site by location within gland &amp; size)</b></p> <p><b>SOURCE #1</b></p> <p><b>Thyroid:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Isthmus<br/>Sublocation: <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower</p> <p><b>Other Source:</b> <input type="checkbox"/> Lymph Node <input type="checkbox"/> Other _____<br/>Type of Biopsy Guidance:<br/><input type="checkbox"/> Ultrasound <input type="checkbox"/> Palpation <input type="checkbox"/> Other: _____</p> <p>Size of lesion (cm): _____</p> <p>Ultrasound Characteristics: (If known)</p> <p><input type="checkbox"/> Hypervascular <input type="checkbox"/> Calcs (type) _____ <input type="checkbox"/> Air-Dried Smears: (#) _____</p> <p><input type="checkbox"/> Cystic <input type="checkbox"/> Solid <input type="checkbox"/> Alcohol Fixed Smears: (#) _____</p> <p><input type="checkbox"/> Irregular Margins <input type="checkbox"/> Mixed Cystic and Solid <input type="checkbox"/> Needle Washings: (ml of fluid) _____</p> | <p><b>Personal History of</b></p> <p><input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Malignancy <input type="checkbox"/> Radioactive Iodine Therapy</p> <p><input type="checkbox"/> Autoimmune Thyroiditis <input type="checkbox"/> MEN</p> <p><input type="checkbox"/> Grave's <input type="checkbox"/> Head &amp; Neck Radiation</p> <p><b>Family History of</b></p> <p><input type="checkbox"/> Thyroid Carcinoma <input type="checkbox"/> MEN</p> <p><input type="checkbox"/> Results of Tests for Antithyroid Antibodies: _____</p> <p><input type="checkbox"/> Prior FNA, Dates, and Diagnosis: _____</p> <p><input type="checkbox"/> Concurrent Levothyroxine Therapy: _____</p> <p><input type="checkbox"/> TSH Level: _____</p> <p><input type="checkbox"/> Scintigraphy and/or PET Results: _____</p> <p><input type="checkbox"/> Additional Information: _____</p> |
| <p><b>SOURCE #2</b></p> <p><b>Thyroid:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Isthmus<br/>Sublocation: <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower</p> <p><b>Other Source:</b> <input type="checkbox"/> Lymph Node <input type="checkbox"/> Other _____<br/>Type of Biopsy Guidance:<br/><input type="checkbox"/> Ultrasound <input type="checkbox"/> Palpation <input type="checkbox"/> Other: _____</p> <p>Size of lesion (cm): _____</p> <p>Ultrasound Characteristics: (If known)</p> <p><input type="checkbox"/> Hypervascular <input type="checkbox"/> Calcs (type) _____ <input type="checkbox"/> Air-Dried Smears: (#) _____</p> <p><input type="checkbox"/> Cystic <input type="checkbox"/> Solid <input type="checkbox"/> Alcohol Fixed Smears: (#) _____</p> <p><input type="checkbox"/> Irregular Margins <input type="checkbox"/> Mixed Cystic and Solid <input type="checkbox"/> Needle Washings: (ml of fluid) _____</p>   |  |
| <p><b>SOURCE #3</b></p> <p><b>Thyroid:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Isthmus<br/>Sublocation: <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower</p> <p><b>Other Source:</b> <input type="checkbox"/> Lymph Node <input type="checkbox"/> Other _____<br/>Type of Biopsy Guidance:<br/><input type="checkbox"/> Ultrasound <input type="checkbox"/> Palpation <input type="checkbox"/> Other: _____</p> <p>Size of lesion (cm): _____</p> <p>Ultrasound Characteristics: (If known)</p> <p><input type="checkbox"/> Hypervascular <input type="checkbox"/> Calcs (type) _____ <input type="checkbox"/> Air-Dried Smears: (#) _____</p> <p><input type="checkbox"/> Cystic <input type="checkbox"/> Solid <input type="checkbox"/> Alcohol Fixed Smears: (#) _____</p> <p><input type="checkbox"/> Irregular Margins <input type="checkbox"/> Mixed Cystic and Solid <input type="checkbox"/> Needle Washings: (ml of fluid) _____</p>   | <p><b>Thyroid Molecular Testing (Special Transport Media Required)</b></p> <p><b>Afirma® GSC/XA -Veracyte</b></p> <p><input type="checkbox"/> Reflex if FLUS/AUS/SFN/FN <input type="checkbox"/> Collect and Hold: _____</p> <p><input type="checkbox"/> Reflex to XA if SM/M</p> <p><b>ThyroSeq® -CBLPath</b></p> <p><input type="checkbox"/> Reflex if FLUS/AUS/SFN/FN/ <input type="checkbox"/> Collect and Hold: _____<br/>Suspicious for Malignancy</p>   |