

Required Information is Highlighted

CellNetix Pathology & Laboratories



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07-21-2025

Patient Information				Specimen Information		
PATIENT LAST NAME	FIRST	M.I.	BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	GENDER ID <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				Referring MDs		
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 <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						
CC report to: First and Last Names						

BREAST PATHOLOGY																																									
<h3>Surgical Procedure</h3> <p><input type="checkbox"/> Core Needle Biopsy</p> <p><input type="checkbox"/> Lumpectomy/ Excisional Biopsy</p> <p><input type="checkbox"/> Other _____</p> <p>Surgeon/Physician: _____</p> <p>Radiologist: _____</p> <p>Technologist: _____</p> <p>Results Appt: Date _____ Time _____</p>	<h3>Specimen Information</h3> <p>(Anatomic Origin of Specimen): Circle One</p> <table border="1"> <tr> <td>A. Right Left</td> <td><input type="checkbox"/> Ultrasound Guided</td> </tr> <tr> <td>Breast, _____ O'CLOCK,</td> <td><input type="checkbox"/> Stereo Guided</td> </tr> <tr> <td>_____ Centimeter from Nipple</td> <td><input type="checkbox"/> MRI Guided</td> </tr> <tr> <td></td> <td><input type="checkbox"/> FNA</td> </tr> <tr> <td>B. Right Left</td> <td><input type="checkbox"/> Ultrasound Guided</td> </tr> <tr> <td>Breast, _____ O'CLOCK,</td> <td><input type="checkbox"/> Stereo Guided</td> </tr> <tr> <td>_____ Centimeter from Nipple</td> <td><input type="checkbox"/> MRI Guided</td> </tr> <tr> <td></td> <td><input type="checkbox"/> FNA</td> </tr> <tr> <td>C. Right Left</td> <td><input type="checkbox"/> Ultrasound Guided</td> </tr> <tr> <td>Breast, _____ O'CLOCK,</td> <td><input type="checkbox"/> Stereo Guided</td> </tr> <tr> <td>_____ Centimeter from Nipple</td> <td><input type="checkbox"/> MRI Guided</td> </tr> <tr> <td></td> <td><input type="checkbox"/> FNA</td> </tr> <tr> <td>D. Right Left</td> <td><input type="checkbox"/> Ultrasound Guided</td> </tr> <tr> <td>Breast, _____ O'CLOCK,</td> <td><input type="checkbox"/> Stereo Guided</td> </tr> <tr> <td>_____ Centimeter from Nipple</td> <td><input type="checkbox"/> MRI Guided</td> </tr> <tr> <td></td> <td><input type="checkbox"/> FNA</td> </tr> <tr> <td>E. Right Left</td> <td><input type="checkbox"/> Ultrasound Guided</td> </tr> <tr> <td>Breast, _____ O'CLOCK,</td> <td><input type="checkbox"/> Stereo Guided</td> </tr> <tr> <td>_____ Centimeter from Nipple</td> <td><input type="checkbox"/> MRI Guided</td> </tr> <tr> <td></td> <td><input type="checkbox"/> FNA</td> </tr> </table>	A. Right Left	<input type="checkbox"/> Ultrasound Guided	Breast, _____ O'CLOCK,	<input type="checkbox"/> Stereo Guided	_____ Centimeter from Nipple	<input type="checkbox"/> MRI Guided		<input type="checkbox"/> FNA	B. Right Left	<input type="checkbox"/> Ultrasound Guided	Breast, _____ O'CLOCK,	<input type="checkbox"/> Stereo Guided	_____ Centimeter from Nipple	<input type="checkbox"/> MRI Guided		<input type="checkbox"/> FNA	C. Right Left	<input type="checkbox"/> Ultrasound Guided	Breast, _____ O'CLOCK,	<input type="checkbox"/> Stereo Guided	_____ Centimeter from Nipple	<input type="checkbox"/> MRI Guided		<input type="checkbox"/> FNA	D. Right Left	<input type="checkbox"/> Ultrasound Guided	Breast, _____ O'CLOCK,	<input type="checkbox"/> Stereo Guided	_____ Centimeter from Nipple	<input type="checkbox"/> MRI Guided		<input type="checkbox"/> FNA	E. Right Left	<input type="checkbox"/> Ultrasound Guided	Breast, _____ O'CLOCK,	<input type="checkbox"/> Stereo Guided	_____ Centimeter from Nipple	<input type="checkbox"/> MRI Guided		<input type="checkbox"/> FNA
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<ul style="list-style-type: none"> • Diagnosis of invasive carcinoma will be tested for ER, PR, and HER-2/neu by immunohistochemistry (IHC) • Diagnosis of DCIS will be tested for ER & PR. 	<h3>Diagnostic Information (ICD-9): Check all that apply:</h3> <table border="1"> <tr> <td><input type="checkbox"/> 611.72 Breast mass</td> <td><input type="checkbox"/> 793.81 Microcalcifications</td> <td><input type="checkbox"/> Numerous</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> <td><input type="checkbox"/> Scanty</td> </tr> <tr> <td><input type="checkbox"/> Calcifications: Confirmed in specimen radiographically</td> <td></td> <td><input type="checkbox"/> Clustered</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Scattered</td> </tr> </table>	<input type="checkbox"/> 611.72 Breast mass	<input type="checkbox"/> 793.81 Microcalcifications	<input type="checkbox"/> Numerous	<input type="checkbox"/> Other: _____		<input type="checkbox"/> Scanty	<input type="checkbox"/> Calcifications: Confirmed in specimen radiographically		<input type="checkbox"/> Clustered			<input type="checkbox"/> Scattered																												
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