BENEFIS HOSPITALS PATHOLOGY
Benefis Hospital East • (406) 455-5436
1101 26th St. So, Great Falls, MT 59405

Benefis HOSPITALS

OUTPATIENT NON-GYN CYTOLOGY REQUISITION

Lab No _____

Patient Name (print) _____ Sex _____ Birthdate ____ / ____ / ____

Doctor Obtaining Specimen _____

Date of Specimen Obtained _____

Provider Signature _____

Specimen Information

____ Sputum (series #____)
____ Urine (series # ____) Instrumented ____ Voided ____
____ Cerebrospinal Fluid
____ Pleural Fluid
____ Peritoneal Fluid
____ Pericardial Fluid
____ Breast Cyst
____ FNA (breast ____ thyroid ____)
____ Other (specify

Laboratory Use Only

Appearance _____ Color _____
Volume _____ By _____
Cytospin made Y N Total #____ W-G ____ Fixed ____
Direct Smears Y N #____
Saccomanno's Y N
Cell Block Y N
IPOX Y N

Clinical Information _____

(eg: prior radiation or chemotherapy)
Previous Exams at Benefis Health System Yes ___ No ___ Previous Benefis Specimen Number _____

PATIENT INFORMATION BELOW MUST BE COMPLETED SO WE MAY FILE INSURANCE

Last Name _____ First _____ Initial___ Soc. Sec.# ___-___ - _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Age ____ Sex ____ Birthdate ____ /____/____ Patient Status: Single ____ Married ____ Other _____

Insured's Name _____ Relationship _____ Soc. Sec.# ___-___ - _____

Insured's Address _____ Insured's Employer _____

Name of 1st Insurance Company _____

Address of 1st Insurance Company _____

Policy # _____ Group # _____

Name of 2nd Insurance Company _____

Address of 2nd Insurance Company _____

Policy # _____ Group # _____