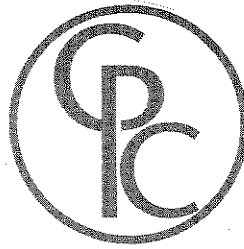


**Consolidated  
Pathology  
Consultants**

28100 N. Ashley Cr., #106  
Libertyville, Illinois 60048  
Phone (877) 631-PATH (7284)  
Fax (847) 996-1076



Patient Data				Billing Information (Continued)					
Name (Last, First)				Responsible Party (Last, First) Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other					
Patient I.D. or SSN		Office MR #		Address		Apt. No.			
Date of Birth (Month, Day, Year)		Date Collected		Time Collected		City State Zip			
<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.					
Physician Signature (Required for Medicaid)		Physician Medicaid #		NPI #		Patient Phone No. ( )			
Additional Reports to:				Medicare I.D. Number		Medicare I.D. Number (incl. Suffix)			
				Primary Insurance Name and Plan				HMO Y <input type="checkbox"/> N <input type="checkbox"/>	
				Policy I.D. Number		Group No.			
Billing Information				Street City State Zip					
<input type="checkbox"/> Account <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance <input type="checkbox"/> Patient									
MEDICARE PATIENTS: Please complete the Advanced Beneficiary Notice (ABN) and attach to the requisition when submitting a specimen.									
ICD Diagnosis Codes (Enter All That Apply) ▶				①		②			
				③		④			

**Clinical Impression/History:**

**NON-GYN CYTOLOGY SPECIMEN:**

Specimen Site	Size of Lesion	Character of Lesion	Fine Needle Aspiration Material
<input type="checkbox"/> Right <input type="checkbox"/> Lymph node	<input type="checkbox"/> < 1 cm	<input type="checkbox"/> Cystic	<input type="checkbox"/> Air-Dried, # of smears: _____
<input type="checkbox"/> Left <input type="checkbox"/> Parotid gland	<input type="checkbox"/> 1 - 2 cm	<input type="checkbox"/> Solid	<input type="checkbox"/> Fixed, # of smears: _____
<input type="checkbox"/> Midline <input type="checkbox"/> Neck mass	<input type="checkbox"/> 2 - 4 cm	<input type="checkbox"/> Single	<input type="checkbox"/> Fluid for cell block: Y N
<input type="checkbox"/> Other <input type="checkbox"/> Thyroid	<input type="checkbox"/> > 4 cm	<input type="checkbox"/> Multiple	<input type="checkbox"/> Other _____
_____ <input type="checkbox"/> Other _____			

**TISSUE BIOPSY SPECIMEN:**

**Specimen Site:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

88172  88173  88304  88305  88312  88313  88342

Ricardo S. Cajulis, M.D.  David D. Wang, M.D., Ph.D.  Thomas F. Mientus, M.D.  
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