

9705 LENEXA DR, LENEXA, KS 66215
(913) 396-8509 (800) 933-6293 Fax (913) 495-9759

| | | | | | |
|-------------------------|---------------------|----------------|--------------|-----|-----|
| Client Name and Address | Patient Name (Last) | First | MI | Sex | DOB |
| | Collection Date | Patient Number | Patient SSN# | | |

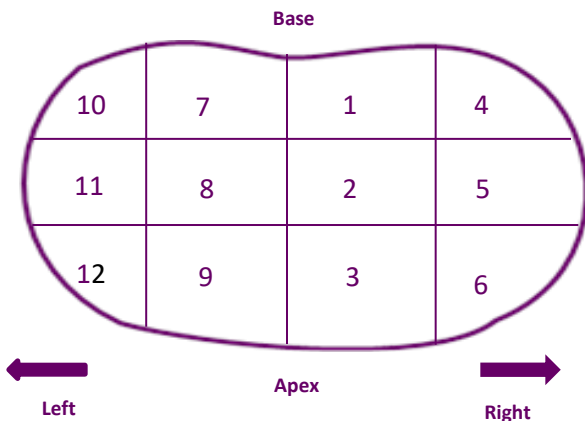
| | |
|---------------------------|-----------------------|
| ORDERING PHYSICIAN | COPY REPORT TO |
| | CC Report To |
| | Address |
| | City State Zip |

| | | | | | | | |
|--|---|------------------------------------|--|--|--|--------------------------------|--------------------------------|
| RESPONSIBLE PARTY & INSURANCE (MAY ATTACH COPIES OF INSURANCE CARDS OR PATIENT DEMOGRAPHIC SHEET) | | | | | | | |
| Bill To | <input type="checkbox"/> Patient (Self) | <input type="checkbox"/> Insurance | <input type="checkbox"/> SEE ATTACHED: Attach All Copies of Insurance | | | | |
| Pt. Relationship to Insured | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | | | | <input type="checkbox"/> Child | <input type="checkbox"/> Other |
| Name of Insured (If Not Self) | | | | | | | |
| Address: City | State | Zip | | | | Insured's SSN#: | |
| Employer's Address | | | | | | | |
| Phone Numbers | Home | Work | | | | | |

| |
|--|
| <input type="checkbox"/> BIOPSY |
| SPECIMEN: _____ |
| PRE-OP DIAGNOSIS: _____ |
| OTHER CLINICAL HISTORY: _____ |
| _____ |

| | | |
|------------------------|---|----------------------|
| Date Collected: | Time Collected: | Collected By: |
| / / | <input type="checkbox"/> a.m. ___ <input type="checkbox"/> p.m. ___ | _____ |

Diagram



| GROSS DESCRIPTION | | | |
|--------------------------|--------------------|---------|-----------|
| | Site | Core(s) | Length(s) |
| | Right Medial Base | | |
| | Right Medial Mid | | |
| | Right Medial Apex | | |
| | Right Lateral Base | | |
| | Right Lateral Mid | | |
| | Right Lateral Apex | | |
| | Left Medial Base | | |
| | Left Medial Mid | | |
| | Left Medial Apex | | |
| | Left Lateral Base | | |
| | Left Lateral Mid | | |
| | Left Lateral Apex | | |
| | | | |
| | | | |

| OTHER TISSUE | |
|---------------------|------|
| Description: | # of |
| | |
| | |
| | |
| | |
| Clinical Info: | |
| | |
| | |
| | |