



**ALASKA NATIVE MEDICAL CENTER
PATHOLOGY DEPARTMENT**

4315 Diplomacy Drive, Anchorage AK 99508

Phone (907) 729-1810

Fax (907) 729-1226

ACCESSION # (LAB ONLY)

CHECK ONE:

SUBMITTING HOSPITAL / CLINIC

<p>CYTOLOGY EXAMINATION <input type="checkbox"/></p> <p>TISSUE EXAMINATION <input type="checkbox"/></p>	
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FOR BREAST ONLY

<p>TIME REMOVED:</p> <p>TIME IN 10% FORMALIN:</p>

PATIENT INFORMATION / LABEL

<p>NAME</p> <p>DOB</p> <p>MR#</p>
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PERTINENT CLINICAL HISTORY/FINDINGS (REQUIRED)

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ICD-10 Codes (REQUIRED)

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SPECIMEN(S):

DATE OBTAINED:

<p>A.</p> <p>B.</p> <p>C.</p> <p>D.</p> <p>E.</p> <p>F.</p>	
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ORDERING PROVIDER OR DESIGNEE

<p>SIGNATURE:</p> <p>PRINT NAME:</p> <p>TITLE OF SIGNER:</p> <p>CALL BACK NUMBER:</p>

*PLEASE COMPLETE ALL AREAS OF THIS FORM