

CyPath[®]Lung



PPLS Use Only: Tech Initial: _____ Result ID: _____ Date/Time: _____	PPLS Accessioning Department Only
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PATIENT INFORMATION			
Last Name		First Name	
Street Address			M.I.
City		Apt. #	State
Patient Phone		Patient SSN	
Date of Birth	Age	Sex	Client ID #
BILLING/INSURANCE			
<input type="checkbox"/> Bill Patient Insurance (Attach copy of insurance card, both sides) Pre-Authorization # _____ <input type="checkbox"/> Bill Patient directly / No insurance <input type="checkbox"/> Bill physician facility			
ICD-10 CODE (REQUIRED)			
<input type="checkbox"/> R91.1 Solitary Pulmonary Nodule <input type="checkbox"/> R91.8 Other non-specific abnormal finding of lung field Other: _____			
CyPath Lung TESTING			
<input type="checkbox"/> CyPath [®] Lung with Acapella [®] Airway Assist Device <i>Flow Cytometry Analysis of Sputum for the Diagnosis of Abnormal finding of lung Field. If inconclusive or inadequate results, reflex to recollection and flow cytometry analysis of sputum.</i>			
CyPath Lung Collection Kit			
<input type="checkbox"/> Kit Provided to patient IN OFFICE <input type="checkbox"/> Kit to be SHIPPED to patient <input type="checkbox"/> Confirm patient address listed above. If different, enter below			
Shipping Address			Apt. #
City		State	Zip
Physician's Office Instruction			
<input type="checkbox"/> Write patient name and date of birth on specimen cup if providing patient kit direct <input type="checkbox"/> Provide patient with collection card and patient coach information. Patient Coach will reach out to patient to train and schedule 3-day collection plan listed below.			
3 Day Collection Plans:			
<ul style="list-style-type: none"> • Sunday, Monday, Tuesday • Monday, Tuesday, Wednesday • Tuesday, Wednesday, Thursday • Saturday, Sunday, Monday Ship Date: Last day of collection			

CLIENT INFORMATION	
Client Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Fax:	_____
Email:	_____
Treating Physician	UPIN #
Physician's Signature X _____	
Send Duplicate of Report to:	
Name	_____
Address/Fax	_____

CLINICAL HISTORY (REQUIRED)
Smoking History: Smoking Years: _____ Pack Years: _____ Quit Smoking (>15 years): <input type="checkbox"/> Yes <input type="checkbox"/> No
Low-dose CT or Imaging available <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach copy.
NOTES:
<input type="checkbox"/> No Acapella [®] Airway Assist Device Provided _____ _____ _____ _____

Precision Pathology Laboratory Services
3300 Nacogdoches Road #110 | San Antonio, TX 78217
 Our hours of operation are **Monday–Friday 8:00am to 6:00pm (CST)**. To reach our laboratory, please call **210-646-0890**
Please email completed requisition to reference@precisionpath.us or fax to 210-646-9191
Please write patient name and date of birth on specimen cup