DIAGNOSTIC PATHOLOGY MEDICAL GROUP, INC.

FNA Accession #:_____

Date Specimen Obtained:_____

Pathologist:_____

(Above for Laboratory Use Only)

FINE NEEDLE ASPIRATION CONSULTATION REQUEST

Offices in Sacramento and Roseville

For Appointments or Inquiries: 800-464-0424 or 916-446-0424 • Fax: 916-446-9330

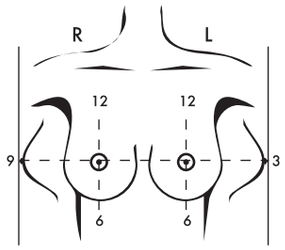
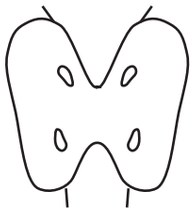
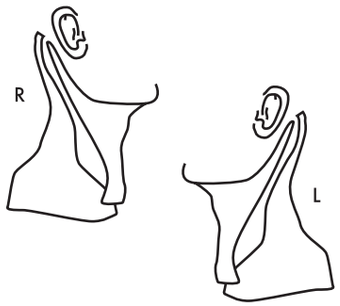
Patient Name: Last, First	Address	City/State	Zip	
Telephone	Date of Birth	Age	☐ Male / ☐ Female Sex	Social Security Number

Physician Name	Address	City/State	Zip	Telephone
CC: Physician Name	Address	City/State	Zip	Telephone

Biopsy Site:	Location / Size of Mass:	Consistency / Shape of Mass:
Clinical Data / Pathologist's Notes:		

Prior Biopsy: ○Y /⊙N If yes, when and where? _____

Imaging Studies Done? ○Y /⊙N If yes, imaging findings? _____

Breast	Thyroid		Physician's Drawings (Optional)
 Distance from Nipple Lump Size			

BREAST IMPLANTS: ○Y /⊙N PREGNANT/NURSING: ○Y /⊙N

FNA CLINIC SLIDE AND CELL BLOCK TALLY

A: MGG (AIR DRIED) X_____ PAP X_____ CELL BLOCK _____

B: MGG (AIR DRIED) X_____ PAP X_____ CELL BLOCK _____

C: MGG (AIR DRIED) X_____ PAP X_____ CELL BLOCK _____

INSURANCE	☐ Copy of insurance card(s) attached	☐ Cash Pay

AUTHORIZATION AND CONSENT:

I have read the information given to me on the Fine Needle Aspiration Biopsy. I understand the potential advantages and risks and have had the opportunity to discuss them and have my questions answered. Potential complications include, but are not limited to: bleeding, swelling, pain and infection. Puncture of adjacent organs may occur. I understand the limitations of this procedure and the medical alternatives available to me.

DPMG may have provided you with a price estimate over the phone. Please be advised that any fees quoted are an estimate only and may change based on actual services performed. You are personally and fully responsible for paying the cost of the services even if higher than originally quoted.

In the event it is determined by the Pathologist that a Fine Needle Aspiration Biopsy procedure cannot be performed during my visit, I fully understand I will be charged for the examination.

Patient's Initial _____

I hereby consent to have Doctor_____ perform a Fine Needle Aspiration on my:_____

Printed name:_____

Signature:_____ Date:_____