Diagnostic Pathology Medical Group, Inc.

DPMG FINE NEEDLE ASPIRATION REQUISITION FORM

Customer Service and Courier Pickup
Phone 916-446-0424
Toll-free 800-464-0424
Fax 916-446-9330

Form completed by: _____

Please fill out this form completely and place completed specimen label on each container

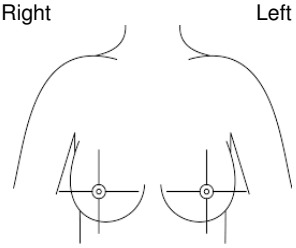
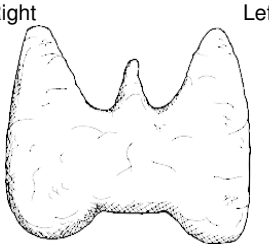
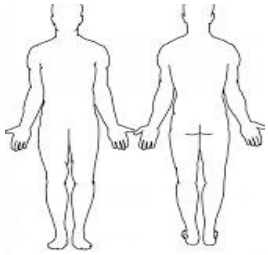
Additional Copies of Report to (Name & Address) _____

Patient Name: Last, First			Date Specimen Taken
Patient Address	City / State	Zip Code	Phone Number
Date of Birth	Age	Sex	SSN

Biopsy Site:	Location / Size Of Mass:	Consistency / Shape of Mass:
ICD 10 Diagnosis Codes (Required for all specimen referrals)		
Clinical Data / 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)
Right Left 	Right Left 	Front Back 	

INSURANCE ☐ Copy of insurance card attached ☐ Cash pay patient