COFFEE REGIONAL MEDICAL CENTER
912−384−1900
Ext 4140
Gerson Paull, M.D., Laboratory Director
1101 Ocilla Road, Douglas, GA 31533

MEDICAL CYTOLOGY REQUEST

3LABDOC

Patient Name:_____ SS#:_____

Address:_____

Sex:_____ Age:_____ DOB:_____

Requesting Physician:_____Address:_____

BILL: ❑ Patient ❑ Insurance ❑ Medicare # _____ ❑ Medicaid #_____
❑ Doctor ❑ Other

BILLING ADDRESS:_____

PROVIDE ALL CLINICAL INFORMATION REQUESTED BELOW

Physician Offices−
For the most updated form please visit
www.coffeeregional.org and
print from the "For Our Physicians" link.

SOURCE OF SPECIMEN

❑ RESPIRATORY LOBE_____

❑ Random Sputum ❑ Induced Sputum
❑ Post Bronch Sputum ❑ BAL ❑ Bronchial Wash ❑ Bronchial Brush

❑ URINE

❑ Voided Urine ❑ Cath Urine ❑ Loop Urine
❑ Bladder Irrigation ❑ Urethral Irrigation ❑ Urethral Wash
❑ Renal Pelvic Wash ❑ Other_____

❑ EFFUSION

❑ Right Pleural Fluid ❑ Left Pleural Fluid ❑ Pericardial Fluid
❑ Right Breast Cyst ❑ Left Breast Cyst ❑ Peritoneal Fluid/Ascites
❑ Joint Fluid_____ ❑ Washings_____

❑ MISCELLANEOUS/SCRAPING

❑ Nipple Discharge R L ❑ Conjunctiva R L ❑ Skin
❑ Other_____

VOLUME:_____**ml**
COLOR:_____ **CLARITY**_____

Patient History:_____

_____

DATE/TIME OBTAINED:_____ **PRIORITY:** ❑ **ROUTINE** ❑ **RUSH**

LABORATORY USE:

DATE/TIME RECEIVED:_____ **ACCESSION NUMBER:**_____

_____
Physician Signature Date/Time

COFFEE REGIONAL MEDICAL CENTER

MEDICAL CYTOLOGY REQUEST

Patient's Name: _____ Date of Birth: _____ SSN: _____

Emergency Contact:_____ Phone: _____

I authorize consent for Coffee Regional Medical Center (CRMC) to perform diagnostic testing and authorize CRMC to release any medical information and documents to Blue Cross Blue Shield, Medicare, Medicaid or other insurance companies for the purpose of completing an insurance claim. I hereby assign to and authorize the direct payment to Coffee Regional Medical Center of any and all insurance or other benefits payable to me for any services rendered. I acknowledge that I am solely responsible for any charges incurred for services provided by Coffee Regional Medical Center. I accept full responsibility for all charges not covered by insurance of for which payment is denied.

I authorize Coffee Regional Medical Center, its service providers (including service providers contacting me about obtaining potential financial assistance for my accounts(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my accounts(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using pre−recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

Additional Provision for Minors: I acknowledge and verify that I am the legal guardian or custodian of minor/incapacitated patient and can legally give legal consent under Georgia Medical Consent Law.

HIPAA Consent/Privacy Notice:
I understand that Coffee Regional Medical Center will use and disclose protected health information about me as a patient or about the patient on whose behalf I am giving this consent to carry our treatment, payment or health care operations and will limit other disclosures as described in the Notice of Privacy Practices ("Notice") of coffee Regional Medical Center. I understand that I have the right to receive a paper copy of this notice upon request by calling (912) 384−1900 ext. 4549 or by visiting our Web Site www.coffeeregional.org.

INDEPENDENT CONTRACTORS: Some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omission of any such independent contractors.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

Date:_____ Time:_____ AM / PM

_____ (SEAL) _____ _____

Patient /Guarantor /Authorized Person Signature | Relation to Patient | Patient Phone Number

Company / Agency_____Phone Number_____

Employee Witness_____ Title_____