Fine Needle Aspirate (FNA) request completion instructions

If you have any questions, contact your Allina Health Laboratory account representative for assistance.

1. Your site demographic information will be pre-printed. Indicate the ordering provider.

2. If not pre-printed, indicate your billing preference; billed to your account, or the patient/insurance.

3. Complete the patient information/demographics including name, gender, date of birth, address and phone number. Insurance information must be provided if you have indicated patient/insurance as the billing indication.

4. If a copy of the report is to be sent to a location/provider other than you, include the full name, location and fax number in this area.

5. Provider signatures *are not required*, providing there is record of the order documented in the patient's chart.
6. If the testing is to be billed to patient/insurance, the patient has Medicare or a Medicare replacement plan and testing is ordered that is affected by medical necessity, indicate if an ABN has been collected.

7. Indicate who performed/collected the FNA, and their position.

8. Indicate the source(s), whether they are an FNA or core biopsy collection and the date and time of collection of each specimen.

9. Indicate name and site verification of this information with initials.

10. Provide any clinical information (i.e. previous malignancy, chemo or radiation therapy etc.). Indicate the diagnosis/reason for the procedure.

11. As applicable, indicate the location, size and consistency of the lesion aspirated on the drawing provided.

12. Indicate any additional testing to be performed on the sample(s).

13. Indicate the number of slides/containers collected for each item listed, as well as the time that the specimen was placed in formalin and/or B+ fixative.

14. If adequacy was assessed by an HPA pathologist, record that, acceptability of prep quality as well as any notes and the preliminary impression, in this area.

    Note: If slides are stained at your facility Prep quality must be assessed and documented by pathologist.

*LAB02 *

ALLINA HEALTH LABORATORY
CYTOLOGY REQUISTION-FNA
2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
(612) 863-4678 • (800) 281-4379
www.allinahealth.org/alllinahealthlaboratory

BILL TO (MUST CHECK ONE): ☐ CLIENT ☐ PATIENT/INSURANCE

DATE & TIME COLLECTED	*DRAWN BY*
PATIENT NAME: Last, First MI	*CHART #*
GENDER: ☐ Male ☐ Female	*BIRTH DATE (mm-dd-yyyy)* - -
PATIENT ADDRESS: Street and city	
STATE *ZIP*	*PATIENT PHONE* ( )

☐ *Attachments included for insurance information*

Note, all MVA and WC related labs will be billed to client regardless of insurance MEDICARE SECONDARY PAYER (MSP) INFORMATION REQUIRED For Medicare patients with open WC or MVA claims, is this testing related to claims? ☐ YES ☐ NO

MEDICARE

MEDICAL ASSISTANCE NUMBER

INSURANCE CO. NAME or INDICATE SELF PAY

Additional copy of the pathology report should be sent to:

Provider: _____
Fax #: _____

POLICY HOLDER'S NAME	RELATIONSHIP OF PATIENT TO INSURED: ☐ Self ☐ Spouse ☐ Dependent ☐ Other
SUBSCRIBER ID #	GROUP #

PROVIDER SIGNATURE

Dx1	Dx2	Dx3	Dx4

Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines, and must include diagnosis, symptom, or reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment, a "signed" Advanced Beneficiary Notice must be included. Clinical consultation regarding test ordering is provided at 612-863-4670.

**Indicates coverage sensitive tests, ABN or waiver may be needed.*

☐ ABN/Waiver NOT INDICATED ☐ ABN/Waiver INCLUDED

FNA Cytology Aspirate (6301C and 12482)

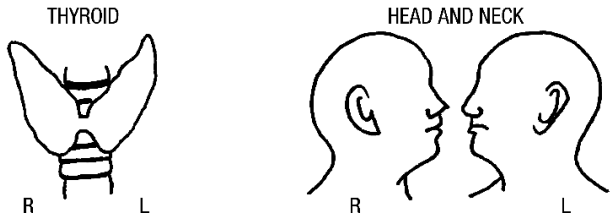
FNA done by Dr. : _____
☐ Clinician ☐ Radiologist ☐ Pathologist ☐ Surgeon

			Date/time collected
Source/Site A: _____	☐ FNA	☐ Core Bx	_____
Source/Site B: _____	☐ FNA	☐ Core Bx	_____
Source/Site C: _____	☐ FNA	☐ Core Bx	_____

Verified:
Name & DOB Initials:_____
Site Initials:_____

CLINICAL INFORMATION ***(Clinical findings, pertinent history, clinical impression, comments, etc.)***

Indicate the location, size and consistency of the lesion aspirated.



ADDITIONAL TESTING (Needle rinse/washout required):

☐ Calcitonin, fine-needle aspiration biopsy (FNAB)-needle wash, lymph node
994, MML CATLN
☐ Parathyroid hormone, fine-needle aspiration biopsy (FNAB)-needle wash, lymph node
994, MML PTHFN
☐ Thyroglobulin, tumor marker, fine-needle aspiration biopsy (FNAB)-needle wash, lymph node
994, MML TFNAB

Indicate number of each slide/container submitted below

Slides/Other	*Source A*	*Source B*	*Source C*
# Air dried slides, unstained			
# Diff-Quik slides			
Cytolyt			
Thyroid RNA transport media			
RPMI			
Formalin Time in: #:			
BPlus			
Needle rinse/washout			
Other miscellaneous:			

For Allina Health Laboratory/Pathologist use only

Adequacy assessed by? ☐ Path ☐ Cytotech Initials _____
Prep/Stain quality acceptable? ☐ Yes ☐ No Initials _____
QA notes:

Preliminary impression:

Apply case label here

Processing Instructions:
RPMI ☐ Hold___ ☐ TP___ ☐ CB___ ☐ Flow___

Misc ☐ Hold___ ☐ TP___ ☐ CB___ ☐ DQ___

Unstained slides ☐ Hold___ ☐ DQ___

Notes:_____
TP=Thin Prep CB=Cell Block DQ=Diff Quik

Apply RQ label here

☐ Ordered by (A#) _____ ☐ 2nd check by (A#) _____