Fine Needle Aspirate (FNA) request completion instructions

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

The numbers of the topics below indicate the position of the information on the FNA request form diagrammed on the following page.

1. Your site demographic information will be pre-printed in this area. Indicate the ordering provider here.

2. If not pre-printed, indicated 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. Indicated 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 verification of information in this area.

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.

*LAB06 *

ALLINA HEALTH LABORATORY
FINE NEEDLE ASPIRATE
2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
Phone: 612-863-4678 • Fax: 612-863-4067
www.allinahealth.org/laboratory

BILL TO: MUST CHECK ONE ☐ CLIENT ☐ PATIENT/INSURANCE 2

☐ MEDICARE SECONDARY PAYER (MSP) INFORMATION REQUIRED. (INTERNAL USE ONLY) MSP status has been verified with beneficiary or representative within 90 days of service and documentation is on file. ☐ **MSP Collected**

1

PATIENT NAME: Last, First MI | CHART #

GENDER: ☐ MALE ☐ FEMALE | BIRTH DATE (mm-dd-yyyy) - -

PATIENT ADDRESS: Street and City 3

PATIENT ADDRESS: State and ZIP | PATIENT PHONE ( )

INSURANCE

☐ **MEDICARE PRIMARY** ☐ **MEDICARE SECONDARY**

MEDICARE #

MEDICAL ASSISTANCE # | STATE

INSURANCE CO. NAME | RELATIONSHIP OF PATIENT TO INSURED ☐ SELF ☐ SPOUSE ☐ DEPEND. ☐ OTHER

POLICY HOLDER'S NAME | POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT) - -

SUBSCRIBER ID # | GROUP #

Additional copy of the pathology report should be sent to:

Provider: _____ 4
First name MI Last name

Fax #:_____

PROVIDER SIGNATURE 5

FNA Cytology Aspirate (6301C and 12482)

FNA done by Dr: _____ 7

☐ Clinician ☐ Radiologist ☐ Pathologist ☐ Surgeon

Medical Necessity Statement: Tests ordered for Medicare patients must follow CMS rules regarding medical necessity/FDA approval guidelines, and must include diagnosis, symptom, or reason for testing as indicated in the medical record. If tests do not come under Medicare guidelines for payment, a "signed" Advanced Beneficiary Notice must be included. Clinical information regarding test ordering is provided at 612-863-4670. **Indicates coverage sensitive tests, ABN may be needed.* 6

☐ ABN NOT INDICATED ☐ ABN INCLUDED

			Date/time collected
Source/Site A: _____ 8	☐ FNA	☐ Core Bx	_____
Source/Site B: _____	☐ FNA	☐ Core Bx	_____
Source/Site C: _____	☐ FNA	☐ Core Bx	_____

Verified:
Name & DOB Initials: 9
Site Initials: _____

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

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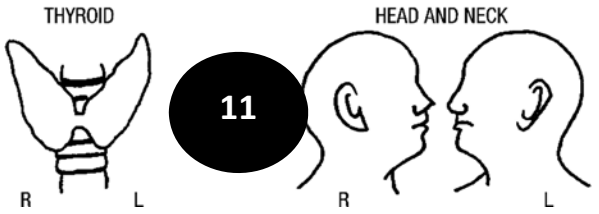
Indicate the location, size and consistency of the lesion aspirated.



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 12

☐ Thyroglobulin, tumor marker, fine-needle aspiration biopsy (FNAB)-needle wash, lymph node
994, MML HTGFN

Indicate number of each slide/container submitted below

Slides/Other	***Source A***	***Source B***	***Source C***
# Air dried slides			
# Fixed slides			
Cytolyt			
Thyroid RNA transport media			
RPMI			
Formalin ***Time in: #:***			
B Plus ***Time in: #:***			
Needle rinse/washout			
Other miscellaneous:			

13

For Allina Health Laboratory/Pathologist use only

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

Preliminary impression: 14

Apply case label here

Processing Instructions:
RPMI ☐ Hold___ ☐ TP___ ☐ CB___ ☐ Flow___
Cytolyt ☐ Hold___ ☐ TP___ ☐ CB___
Misc. ☐ Hold___ ☐ TP___ ☐ CB___ ☐ DQ___
Notes:_____
TP=Thin Prep CB=Cell Block DQ=Diff Quik

Apply RQ label here

CYTOL-FNA (08/2018)

☐ Ordered by (A#) _____