WATERBURY HOSPITAL
64 Robbins Street • Waterbury, CT 06708

LABORATORY
NON - GYN CYTOLOGY

PATIENT NAME

ADDRESS

CITY STATE ZIP

PHONE SEX DATE OF BIRTH

SOCIAL SECURITY NO.

ACCESSION NUMBER:

SPECIMEN SOURCE:

DATE COLLECTED: DATE RECEIVED:

PHYSICIAN NAME:

PHYSICIAN SIGNATURE: DATE/TIME:

PHYSICIAN ADDRESS:

CLINICAL INFORMATION:

ICD CODE

INSURANCE

EMPLOYER	MEDICARE # (SUFFIX)
NAME OF POLICY HOLDER (IF OTHER THAN PATIENT)	MEDICAID #
RELATIONSHIP TO PATIENT	BLUE CROSS / BLUE SHIELD SUBSCRIBER #
ADDRESS	OTHER INSURANCE (NAME)
CITY STATE ZIP	GROUP # CONTACT #

CYTOPREP WORKSHEET:

CN 3143 REV 6/17