TRUMBULL LABS
&
PATHOLOGY GROUP
OF THE MIDSOUTH

Patient Referral: Consultation for Ultrasound Guided Fine Needle Aspiration with Pathologic Interpretation

Date______________

Patient Information:

Patient Name (First)___________________________ (M.I.)_____ (Last)____

Patient Address____

City____ State_______________________ Zip Code___________________

Social Security Number____________________________________ Date of Birth_______________________ Sex_________

Phone: Home________________________ Cell___________________________ Work________________________________

Please attach your patient demographic sheet and a copy of the patient's insurance card
For this service we do not accept patients with Cigna or UHC.
Office Staff or Patient may call (901)542-6800 to schedule this procedure.

Referring Physician____

Address____

Phone________________________________ Nurse/Office Contact____

Please check to indicate the test being requested:

◯ *Consultation with Ultrasound Guided Fine Needle Aspiration and Pathologic Interpretation*

*of the*____
Anatomic site

Clinical History/Diagnosis____

____

Please include recent office visit notes, lab tests, & imaging studies, if performed.

Referring Physician's Signature____

FAX FORM & ATTACHMENTS TO TRUMBULL LABORATORIES,LLC (901)542-6873
PGM Tax ID # 62-1319565