

OUTPATIENT CYTOPATHOLOGY CENTER

PATIENT REFERRAL FORM

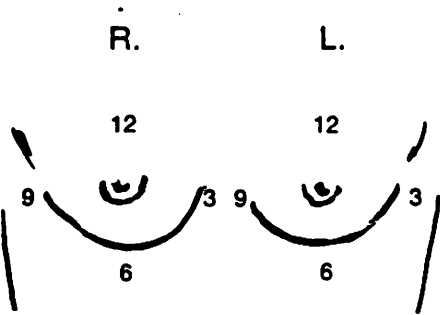
Name: _____ Appointment Date: _____
Address: _____ Appointment Time: _____
DOB: _____ Age _____ Sex _____
Referring Physician: _____

*Biopsy Site(s): (1) _____ (2) _____ (3) _____

Clinical History _____

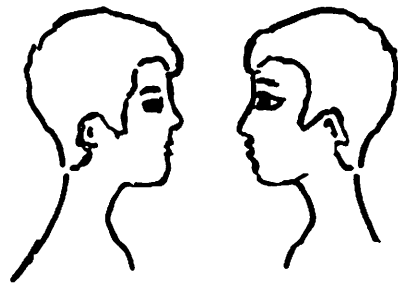
BREAST

R. L.



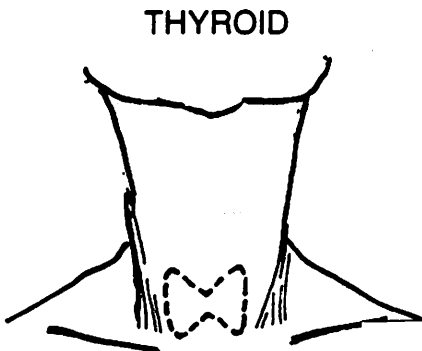
DISTANCE FROM NIPPLE _____

LUMP SIZE _____

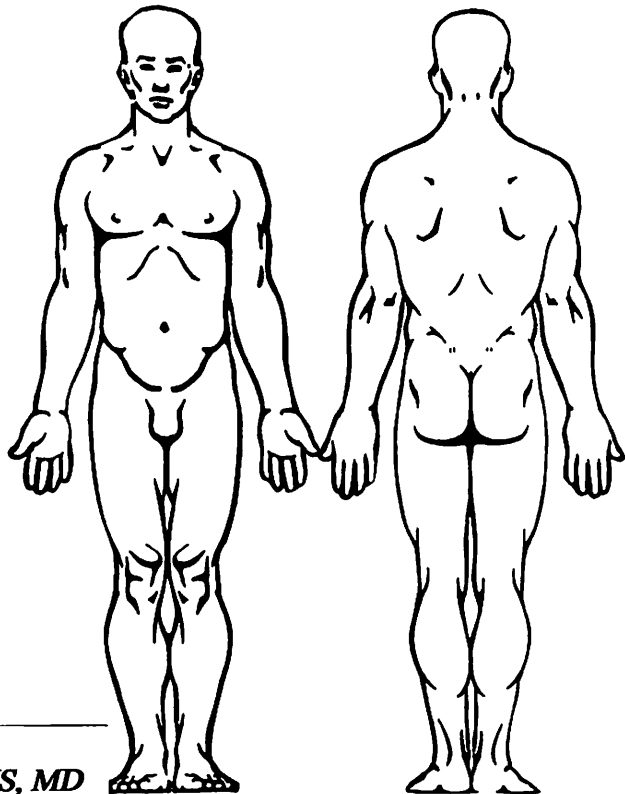


LUMP SIZE _____

PHYSICIAN'S
OPTIONAL DRAWING



LUMP SIZE _____



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