

PRECISION ASPIRATION and BIOPSY



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**FINE NEEDLE ASPIRATION  
REFERRAL FORM**

Patient Name: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ ICD-9 Code(s): \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Site of mass (lump): \_\_\_\_\_

Pertinent Patient History: \_\_\_\_\_

\_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_

\* Please fax this form and any accompanying radiology reports to the above number.