

PATHOLOGY REFERENCE LABORATORY, L.L.C.



CYTOPATHOLOGY REQUISITION

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COLLECTION DATE: _____

____/____/____

BILL TO:

- CLIENT
- PATIENT
- OTHER

ACCOUNT NAME AND ADDRESS

PATIENT LAST NAME _____ FIRST _____ M.I. _____

RELATIONSHIP TO INSURED: SELF SPOUSE DEPENDENT

PHONE () _____ PATIENT SS # _____ PATIENT ID/MR # _____ DATE OF BIRTH / / _____ SEX F M

INSURED NAME/RESPONSIBLE PARTY _____ INSURED SS # _____

PATIENT ADDRESS (OR INSURED RESPONSIBLE PARTY) _____ APT. NO. _____

CITY _____ STATE _____ ZIP _____

EMPLOYEE NAME _____ PHONE () _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY PHONE () _____ INSURANCE/GROUP # _____ MEMBER/SUBSCRIBER ID # _____

MEDICARE # _____ SUFFIX PRIMARY SECONDARY MEDICAID # _____ STATE _____

SURGICAL PATHOLOGY

| SURGEON: | TISSUE SUBMITTED | ICD-9 CODES |
|--------------------|------------------|-------------|
| HISTORY: | 1. | 1. |
| CLINICAL DIAGNOSIS | 2. | 2. |
| | 3. | 3. |
| | 4. | 4. |

CYTOPATHOLOGY

PLEASE HAVE MEDICARE PATIENTS REVIEW AND SIGN THE SEPARATE ADVANCED BENEFICIARY (ABN) FORM FOR NON-COVERED SERVICES.

GYNECOLOGIC

PLEASE CHECK ONE BOX IN THIS SECTION

- SCREENING PAP:** Routine (V72.31)
- SCREENING PAP:** High risk of cervical cancer, screening recommended by physician more often than normal based history (V76.2)
- DIAGNOSTIC PAP SMEAR:** History, signs or symptoms of abnormality (ICD-9 code required in space below)

- CERVIX VAGINA **ICD-9 DIAGNOSIS CODE (Required):** _____
- THIN PREP + IMAGING THIN PREP SUREPATH PAP SMEAR (1 OR 2 SLIDES)

- REFLEX HPV WHEN ASCUS
 - REFLEX HPV WHEN ASCUS OR LSIL
 - HPV REGARDLESS OF PAP RESULT
 - HPV ONLY
 - HIGH/LOW RISK
 - HIGH RISK ONLY

IF NONE MARKED - HIGH RISK WILL BE PERFORMED

- CHLAMYDIA & GONORRHEA CHLAMYDIA ONLY GONORRHEA ONLY
- GROUP B STREP* HERPES SIMPLEX I & II* *(ONLY FROM LIQUID BASE PAP SPECIMEN)

NON-GYNECOLOGIC

INDICATION FOR STUDY _____

ICD-9 _____

SPECIMEN SOURCE _____

- SPUTUM
- BRONCHUS
- BREAST DISCHARGE
- BREAST CYST
- ESOPHAGUS
- URINE
- OTHER _____

FINE NEEDLE BIOPSY-SITE: _____

LAST MENST PERIOD: _____ DATE OF LAST SMEAR: _____

PREVIOUS RESULTS: NORMAL REACTIVE AGUS ASCUS LGSIL HGSIL

CLINICAL HISTORY, CHECK ALL THAT APPLY:

- ROUTINE
- PREV ABNL PAP
- TOTAL HYSTERECTOMY
- POST PARTUM
- POSTMENOPAUSAL
- SUPRACERVICAL HYSTERECTOMY
- IUD
- BIRTH CONTROL PILL
- PREVIOUS RADIATION OR CHEMO
- DEPO-PROVERA
- IMMUN OSUPPRESSED
- PREGNANT _____ WEEKS
- HORMONE THERAPY: PLEASE SPECIFY _____

HIGH RISK INFORMATION:

- DES EXPOSURE
- EARLY SEXUAL ACTIVITY
- MULTIPLE SEXUAL PARTNERS
- HISTORY OF STD
- NO PAP LAST SEVEN YEARS