

CALL
 FAX

STAT

Note:
PAP testing is designated a Frequency test © and must have a signed ABN accompany the requisition.

PATIENT INFORMATION Please Provide All Information below (Name on Requisition MUST Match Name on Specimen EXACTLY!)							FOR LAB USE ONLY
LAST NAME (Please Print Legibly)	FIRST	MIDDLE	PATIENT SS#	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH [MM / DD / YYYY]		LAB ID:
PATIENT ADDRESS			CITY	STATE	ZIP CODE	HOME PHONE	RCVD TIME/DATE:
COLLECTION DATE:	TIME:	<input type="checkbox"/> A.M. <input type="checkbox"/> Fasting <input type="checkbox"/> P.M. <input type="checkbox"/> Non-Fasting	PATIENT MRN.		NAME OF GUARANTOR:		<input type="checkbox"/> Slide(s) <input type="checkbox"/> Pap Prep <input type="checkbox"/> Histo
REQUESTING PHYSICIAN [Last Name, First Name]			BILLING INFORMATION (Required)				TRANSCRIPTION:
			BILL: <input type="checkbox"/> CLIENT/ OFFICE <input type="checkbox"/> PATIENT/ INSURANCE		Please provide a photo copy of the patient's insurance card(s)		
			PRIMARY INSURANCE CARRIER		2 nd - INSURANCE CARRIER		
			POLICY/ MEMBER/ MEDICARE NUMBER		2 nd - POLICY/ MEMBER/ MEDICARE NUMBER		
			GROUP NUMBER/ PERSONAL CODE		2 nd - GROUP NUMBER/ PERSONAL CODE		
			POLICY HOLDER		2 nd - POLICY HOLDER		
			EMPLOYER		2 nd - EMPLOYER		
CONSULTING COPY TO PHYSICIAN(s) [Last Name, First Name] (COMPLETE MAILING ADDRESS or FAX NUMBER is REQUIRED to SEND a CONSULT REPORT)			When ordering tests for which Medicare reimbursement will be sought, physicians should only order tests which are medically necessary for the diagnosis or treatment of the patient. Medicare will not pay for screening tests.				
			1. 2. 3. 4. 5. 6.				
			Link each ICD9 code above to the test by writing the box number next to the corresponding test name.				

CODE	X	GYN CYTOLOGY (PAPS)	ICD-9	SPECIMEN	DERMATOLOGY / SURGICAL CLINICAL HISTORY	05.28.2009
8090002	<input type="checkbox"/>	Pap, Sure Path © (Liquid Based) Indicate Reflex Action for Pap by checking box below <input type="checkbox"/> HPV High Risk - Perform Regardless Sure Path Vial <input type="checkbox"/> HPV 16/18 Genotype if HPV High Risk is Positive Sure Path Vial <input type="checkbox"/> HPV 16/18 Genotype - Perform Regardless Sure Path Vial <input type="checkbox"/> HPV High Risk - If PAP is ASCUS Sure Path Vial <input type="checkbox"/> HPV High Risk if PAP ASCUS, if positive HPV 16/18 Genotype Sure Path Vial <input type="checkbox"/> HPV High Risk - If PAP is Abnormal Sure Path Vial <input type="checkbox"/> HPV High Risk if PAP Abnormal, if positive HPV 16/18 Genotype Sure Path Vial		Sure Path Vial	Check all that apply: <input type="checkbox"/> Prior Surgery at same site <input type="checkbox"/> Prev. Dx Malignancy Type: Case# Clinical History:	
5522725	<input type="checkbox"/>	HPV High Risk, no PAP		Sure Path Vial		
1516355	<input type="checkbox"/>	HPV 16/18 Genotype if HPV High Risk is Positive, no PAP		Sure Path Vial		
1516350	<input type="checkbox"/>	HPV 16/18 Genotype Only, no PAP		Sure Path Vial		
8090002	<input type="checkbox"/>	Pap, Conventional © (# of slides: _____) - Please provide a Source for the tests below - Source: _____		Slide		
5560330	<input type="checkbox"/>	GC/Chlamydia Probe on SWAB (Preferred Sample)				
5560330	<input type="checkbox"/>	GC/Chlamydia Probe on Sure Path Pap...				
6000255	<input type="checkbox"/>	Group B Streptococcus Culture...				
6002005	<input type="checkbox"/>	Urogenital Culture...				
6000650	<input type="checkbox"/>	WET PREP for Yeast & Trichomonas...				
GYN CYTOLOGY CLINICAL HISTORY * * Required information if ordering Gynecological Cytology * * Last Menstrual Period (LMP) Date: ____/____/____ Specimen Site: <input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical <input type="checkbox"/> Vaginal Previous PAP Date: ____/____/____ Previous Biopsy Date: ____/____/____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Other Result: Please check all that apply: <input type="checkbox"/> Routine Exam <input type="checkbox"/> * Hx of Gyn Malignancy; Rx/Surgery <input type="checkbox"/> Estrogen Therapy <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Hysterectomy, cervix intact <input type="checkbox"/> * Abnormal Exam, HPV lesion <input type="checkbox"/> * Contraceptives <input type="checkbox"/> Hysterectomy, total <input type="checkbox"/> * Atypical Pap in last 2 yr <input type="checkbox"/> * Pelvic Radiation <input type="checkbox"/> Pregnant _____wks <input type="checkbox"/> Post Menopausal <input type="checkbox"/> * History of HPV, Rx <input type="checkbox"/> Postpartum _____wks <input type="checkbox"/> Post Menopausal Bleed * If yes, please explain: _____ <input type="checkbox"/> * Other risk factors						
DERMATOLOGY / SURGICAL PATHOLOGY						
6002009	<input type="checkbox"/>	Culture for Helicobacter pylori (H. pylori)			Source: _____	
6000300	<input type="checkbox"/>	Fungus Culture			Source: _____	
6000455	<input type="checkbox"/>	Herpes Culture			Source: _____	
6000153	<input type="checkbox"/>	Aerobic Culture			Source: _____	
6300100	<input type="checkbox"/>	KOH Prep			Source: _____	
8090000	<input type="checkbox"/>	Histologic Pathology			Anatomical Site / Clinical Information	
		Spec. # 1				
		Spec. # 2				
		Spec. # 3				
		Spec. # 4				
		Spec. # 5				
		Spec. # 6				

NON-GYN CYTOLOGY						
5601525	<input type="checkbox"/>	UROVYSION (Bladder Cancer) Collect Mon.- Wed. before 3pm only, deliver ASAP! Please indicate urine source: Urine <input type="checkbox"/> Voided Random <input type="checkbox"/> Bladder wash <input type="checkbox"/> Catheterized <input type="checkbox"/> Indwelling catheter Urine must be fixed and refrigerated (Fix: 30mL urine plus 15mL UroVysion preservative)	8090001	<input type="checkbox"/>	CYTOLOGY Please list source below <input type="checkbox"/> Body Fluid Source: _____ <input type="checkbox"/> Breast <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Cyst fluid <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Solid mass aspiration <input type="checkbox"/> Ductal Lavage <input type="checkbox"/> Bronchial <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Washing <input type="checkbox"/> Brushing <input type="checkbox"/> Lavage <input type="checkbox"/> Urine <input type="checkbox"/> Voided <input type="checkbox"/> Catheterized <input type="checkbox"/> Bladder wash <input type="checkbox"/> Indwelling catheter	<input type="checkbox"/> Fine Needle Aspiration Source: _____ <input type="checkbox"/> Cerebral Spinal Fluid (CSF) <input type="checkbox"/> Sputum <input type="checkbox"/> Other: _____