RML REGIONAL MEDICAL LABORATORY
1923 S. Utica Ave. Tulsa, OK 74104 (918) 744-2500
WWW.RMLONLINE.COM (800) 722-8077

|--------- RML USE ONLY ---------|
| PLACE BR1 LABELS HERE |
|--------- RML USE ONLY ---------|

☐ 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
LAB ID:
RCV'D TIME/DATE:
☐ Slide(s)
☐ Pap Prep
☐ Histo
TRANSCRIPTION:

LAST NAME (Please Print Legibly) | FIRST | MIDDLE | PATIENT SS# | SEX M☐ F☐ | DATE OF BIRTH [MM / DD / YYYY]

PATIENT ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE

COLLECTION DATE: | TIME: ☐ A.M. ☐ P.M. | ☐ Fasting ☐ Non-Fasting | PATIENT MRN. | NAME OF GUARANTOR:

REQUESTING PHYSICIAN [Last Name, First Name]

BILLING INFORMATION (Required)

BILL: ☐ CLIENT/ OFFICE ☐ PATIENT/ INSURANCE

Please provide a photo copy of the patient's insurance card(s)

PRIMARY INSURANCE CARRIER	2nd - INSURANCE CARRIER
POLICY/ MEMBER/ MEDICARE NUMBER	2nd - POLICY/ MEMBER/ MEDICARE NUMBER
GROUP NUMBER/ PERSONAL CODE	2nd - GROUP NUMBER/ PERSONAL CODE
POLICY HOLDER	2nd - POLICY HOLDER
EMPLOYER	2nd - EMPLOYER

CONSULTING COPY TO PHYSICIAN(s) [Last Name, First Name]
(COMPLETE MAILING ADDRESS or FAX NUMBER is REQUIRED to SEND a CONSULT REPORT)

Indicate if reason for visit is related to Hospice Care: **YES** ☐ **NO** ☐

Provide the Name of Hospice: ____________

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. Physicians should only order tests which are medically necessary for the diagnosis or treatment of the patient. **Medicare will not pay for screening tests.**

GYN CYTOLOGY (PAPS)

CODE	X	GYN CYTOLOGY (PAPS)	ICD-9	SPECIMEN
8090002	☐	**Pap, Sure Path** ◎ **(Liquid Based)**		Sure Path Vial
		Indicate Reflex Action for Pap by checking box below		
		☐ HPV High Risk - Perform Regardless		Sure Path Vial
		☐ HPV 16/18 Genotype if HPV High Risk is Positive		Sure Path Vial
		☐ HPV 16/18 Genotype - Perform Regardless		Sure Path Vial
		☐ HPV High Risk - If PAP is ASCUS		Sure Path Vial
		☐ HPV High Risk if PAP ASCUS, if positive HPV 16/18 Genotype		Sure Path Vial
		☐ HPV High Risk - If PAP is Abnormal		Sure Path Vial
		☐ HPV High Risk if PAP Abnormal, if positive HPV 16/18 Genotype		Sure Path Vial
5522725	☐	HPV High Risk, **no PAP**		Sure Path Vial
1516355	☐	HPV 16/18 Genotype if HPV High Risk is Positive, **no PAP**		Sure Path Vial
1516350	☐	HPV 16/18 Genotype Only, **no PAP**		Sure Path Vial
8090002	☐	**Pap, Conventional** ◎ (# of slides:________________)		Slide
		- Please provide a Source for the tests below -		***Source:***
5560330	☐	GC/Chlamydia Probe on **SWAB (Preferred Sample)**		
5560330	☐	GC/Chlamydia Probe on **Sure Path Pap**...		
6000255	☐	Group B Streptococcus Culture...		
6002005	☐	Urogenital Culture...		
6000650	☐	WET PREP for Yeast & Trichomonas...		
6002525	☐	Yeast Culture		

GYN CYTOLOGY CLINICAL HISTORY

*** * Required information if ordering Gynecological Cytology * ***

Last Menstrual Period (LMP) Date: ____/____/____
Specimen Site: ☐ Cervical ☐ Endocervical ☐ Vaginal

Previous PAP Date:___/___/___ **Previous Biopsy Date:** ___/___/___
Result: ☐ Normal ☐ Abnormal ☐ Other **Result:**

Please check all that apply:

☐ Routine Exam	☐ * Hx of Gyn Malignancy: Rx/Surgery	☐ Estrogen Therapy
☐ Abnormal Bleeding	☐ Hysterectomy, cervix intact	☐ * Abnormal Exam, HPV lesion
☐ * Contraceptives	☐ Hysterectomy, total	☐ * Atypical Pap in last 2 yr
☐ * Pelvic Radiation	☐ Pregnant _______wks	☐ Post Menopausal
☐ * History of HPV, Rx	☐ Postpartum______wks	☐ Post Menopausal Bleed
		☐ * Other risk factors

* If yes, please explain:

DERMATOLOGY / SURGICAL CLINICAL HISTORY

1.09.2012

Check all that apply:

☐ Prior Surgery at same site ☐ Prev. Dx Malignancy

Type: Case#

Clinical History:

DERMATOLOGY / SURGICAL PATHOLOGY

CODE	X	DERMATOLOGY / SURGICAL PATHOLOGY
6000130	☐	Acid Fast Culture direct (AFB) — *Source:*
6000153	☐	Aerobic Culture — *Source:*
6000300	☐	Fungus Culture — *Source:*
6002009	☐	Helicobacter pylori Culture (H. pylori) — *Source:*
6000455	☐	Herpes Culture — *Source:*
6300100	☐	KOH Prep — *Source:*
8090000	☐	**Histologic Pathology** Anatomical Site / Clinical Information

Spec.# **1** Spec.# **4**

Spec.# **2** Spec.# **5**

Spec.# **3** Spec.# **6**

ALL BREAST SPECIMENS (All Tumors must be in Contact of Formalin w/in 60min of Collection)

Collection Time: ☐ A.M. ☐ P.M.	Time of Biopsy in Formalin: ☐ A.M. ☐ P.M.	Time of Tumor in Formalin: ☐ A.M. ☐ P.M.

NON-GYN CYTOLOGY

9500000 ☐ **URINE FISH** (Bladder Cancer)

Place Urine in Container with Preservative from kit ASAP
Optimal Stability with preservative is 72hrs.
Please indicate urine source:
30-60mL Urine ☐ Voided Random
☐ Bladder wash
☐ Catheterized
☐ Indwelling catheter
*(Note: Do Not Collect the First Morning Void)

8090001 ☐ **CYTOLOGY Please list source below**

☐ **Body Fluid** ***Source:***

☐ **Fine Needle Aspiration** ***Source:***

☐ **Breast** ☐ Right ☐ Left ☐ Cyst fluid ☐ Nipple discharge ☐ Solid mass aspiration ☐ Ductal Lavage

☐ **Cerebral Spinal Fluid** (CSF)

☐ **Bronchial** ☐ Washing ☐ Brushing ☐ Lavage
Right: ☐RUL ☐RML ☐RLL ***Left:*** ☐LUL ☐LLL

☐ **Sputum**

☐ **Urine** ☐ Voided ☐ Bladder wash ☐ Catheterized ☐ Indwelling catheter

☐ **Other:**