RML
REGIONAL MEDICAL LABORATORY
4142 S Mingo Rd. Tulsa, OK 74146 (918) 744-2500
WWW.RMLONLINE.COM (800) 722-8077

☐ 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!)**

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:

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

REQUESTING PHYSICIAN [Last Name, First Name]

Provider signature: _____
The tests that are ordered within this requisition are medically necessary for the treatment of this patient.

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

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

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 DX 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.**

ORDER	GYN CYTOLOGY
PAP 1	☐ Gyn Pap Test, ThinPrep, Image Guided
PAP 2 AGE 21-29	☐ Gyn Pap Test, ThinPrep, Image Guided, Reflex to HPV if ASCUS
PAP 3 AGE 30-65	☐ Gyn Pap Test, ThinPrep, Image Guided and HPV
PAP 4 AGE 30-65	☐ Gyn Pap Test, ThinPrep, Image Guided and HPV with Reflex to Genotypes 16, 18/45
PAP 5	☐ Gyn Pap Test, Image Guided, Reflx to HPV if ASCUS or AGUS
PAP 6	☐ Gyn Pap Test, Image Guided, Reflx to HPV if ASCUS or AGUS, Reflx to Genotype 16, 18/45
PAP 7	☐ Gyn Pap Test, Image Guided, Reflx to HPV if ASCUS, ASC-H, or AGUS
PAP 8	☐ Gyn Pap Test, Image Guided, Reflx to HPV if ASCUS, ASC-H, or AGUS, Rflx to Genotype 16, 18/45
PAP 9	☐ Gyn Pap Test, Image Guided, Reflx to HPV if ASCUS, Rflx to Genotype 16, 18/45
PAP 10	☐ Gyn Pap Test, Image Guided, Reflx to HPV if ASCUS, ASC-H, AGUS or LSIL
PAP 11	☐ Gyn Pap Test, Image Guided, Reflx to HPV if ASCUS, ASC-H, AGUS or LSIL, Reflx to Genotype 16, 18/45

ORDER	ADDITIONAL GYN INFECTION TESTING	ORDER	ADDITIONAL GYN INFECTION TESTING
	Chlamydia Trachomatis (CT)		Trichomonas Vaginalis
CT Pap	☐ ThinPrep Pap	Trich Pap	☐ ThinPrep Pap
CT Swab	☐ Aptima Swab	Trich Swab	☐ Aptima Swab
CT Urine	☐ Aptima Urine	Trich Urine	☐ Aptima Urine
	Neisseria Gonorrhoeae (GC)	Vag Prof Out	☐ Vaginal Profile Saline, with pH, Outreach
GC Pap	☐ ThinPrep Pap	Vag Molec	☐ Vaginosis Molecular Panel (BD Affirm, BD Swab)
GC Swab	☐ Aptima Swab		Herpes Simplex Virus 1 and 2 (HSV), DNA, PCR
GC Urine	☐ Aptima Urine	HSV PCR QL	☐ HSV 1 and 2 PCR (Swab in viral transport media)
	Chlamydia Trachomatis (CT) & Neisseria Gonorrhoeae (GC)	C Strep B	☐ Group B Strep Culture (ESwab)
CT/GC Pap	☐ ThinPrep Pap	C Urog	☐ Urogenital Culture (ESwab)
CT/GC Swab	☐ Aptima Swab	Wet Prep	☐ Wet Prep for Yeast and Trichomonas (Swab in saline or ESwab)
CT/GC Urine	☐ Aptima Urine	C Yeast	☐ Yeast Culture (ESwab)

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
☐ Abnormal Bleeding
☐ * Contraceptives
☐ * Pelvic Radiation
☐ * History of HPV, Rx
* If yes, please explain:
☐ * Hx of Gyn Malignancy; Rx/Surgery
☐ Hysterectomy, cervix intact
☐ Hysterectomy, total
☐ Pregnant _____wks
☐ Postpartum _____wks
☐ Estrogen Therapy
☐ * Abnormal Exam, HPV lesion
☐ * Atypical Pap in last 2 yr
☐ Post Menopausal
☐ Post Menopausal Bleed
☐ * Other risk factors

DERMATOLOGY / SURGICAL CLINICAL HISTORY 1.09.2012

Check all that apply:

☐ Prior Surgery at same site ☐ Prev. Dx Malignancy

Type: Case#

Clinical History:

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.# **A**			Spec.# **D**
Spec.# **B**			Spec.# **E**
Spec.# **C**			Spec.# **F**

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

8090001 ☐ **CYTOLOGY Please list source below**

☐ **Body Fluid** *Source:*

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

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

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

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

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

☐ **Cerebral Spinal Fluid** (CSF)

☐ **Sputum**

☐ **Other:**