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RML
REGIONAL MEDICAL LABORATORY

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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.
Completed by: _____

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 ThinPrep
PAP 1	☐ Gyn Pap Test, Image Guided
PAP 2 AGE 21-29	☐ Gyn Pap Test, Image Guided, Reflex to HPV if ASCUS
PAP 3 AGE 30-65	☐ Gyn Pap Test, Image Guided and HPV
PAP 4 AGE 30-65	☐ Gyn Pap Test, 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
CT PAP	☐ C. Trachomatis ThinPrep PAP	Trich PAP	☐ Trichomonas Vaginalis ThinPrep PAP
CT Swab	☐ C. Trachomatis Aptima Swab	Trich Swab	☐ Trichomonas Vaginalis Aptima Swab
CT Urine	☐ C. Trachomatis Aptima Urine	Trich Urine	☐ Trichomonas Vaginalis Aptima Urine
GC PAP	☐ N. Gonorrhoeae ThinPrep PAP	V PROF SWB	☐ Vaginosis Profile, Trich AG, no pH (ESwab)
GC Swab	☐ N. Gonorrhoeae Aptima Swab	VAG MOLEC	☐ Vaginosis Molecular Pnl (BD Affirm, BD Swab)
GC Urine	☐ N. Gonorrhoeae Aptima Urine	HSV SWAB	☐ HSV 1+2 (Aptima Swab, UTM)
CT/GC PAP	☐ CT/GC ThinPrep PAP	C STREP B	☐ Group B Strep Culture (ESwab)
CT/GC Swab	☐ CT/GC Aptima Swab	C UROG RTS	☐ Urogenital Culture (ESwab)
CT/GC Urine	☐ CT/GC Aptima Urine	MySwab STD	☐ HSV 1+2, Trich, CT, GC Aptima Swab

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

Please check all that apply:
- ☐ Routine Exam
- ☐ Abnormal Bleeding
- ☐ * Contraceptives
- ☐ * Pelvic Radiation
- ☐ * History of HPV, Rx
- ☐ * Hx of Gyn Malignancy; Rx/Surgery
- ☐ Hysterectomy, cervix intact
- ☐ Hysterectomy, total
- ☐ Pregnant _____wks
- ☐ Postpartum _____wks

* If yes, please explain:

Result:
- ☐ Estrogen Therapy
- ☐ * Abnormal Exam, HPV lesion
- ☐ * Atypical Pap in last 2 yr
- ☐ Post Menopausal
- ☐ Post Menopausal Bleed
- ☐ * Other risk factors

DERMATOLOGY / SURGICAL CLINICAL HISTORY 9-2019

Check all that apply:

☐ Prior Surgery at same site ☐ Prev. Dx Malignancy

Type: Case#

Clinical History:

CODE	X	DERMATOLOGY / SURGICAL PATHOLOGY
6000153	☐	Aerobic Culture
		Source:
6000050	☐	Anaerobic Culture
		Source:
6000300	☐	Fungus Culture
		Source:
6000130	☐	Acid Fast Culture Direct (AFB)
		Source:
6000455	☐	Herpes Culture
		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:*

6905153 ☐ **UroVysion FISH** (Bladder Cancer)

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

☐ **Breast**	☐ Right ☐ Left	☐ Cyst fluid ☐ Nipple discharge	☐ Solid mass aspiration ☐ Ductal Lavage	☐ **Cerebral Spinal Fluid** (CSF)
☐ **Bronchial**	☐ Washing	☐ Brushing	☐ Lavage	☐ **Sputum**
	Right: ☐ RUL ☐ RML	☐ RLL ***Left:*** ☐ LUL	☐ LLL	
☐ **Urine**	☐ Voided ☐ Bladder wash	☐ Catheterized ☐ Indwelling catheter		☐ **Other:**