The Pathology Center

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D R O 0 2 0

For Laboratory Use:

CYTOLOGY

PAP SOURCE: ☐ Cervical/Vaginal ☐ Cervical ☐ Vaginal
LMP Date:_____/_____/_____
CHOOSE ONLY ONE

- ☐ Pap Smear (Conventional glass slide)
- ☐ Liquid-Based Pap No HPV Testing
- ☐ Liquid-Based Pap and **REFLEX** HPV High Risk with 16 and 18 Genotyping (HPV testing for ASCUS and AGUS diagnoses)
- ☐ Liquid-Based Pap and **CO-TEST** HPV High Risk with 16 and 18 Genotyping
- ☐ HPV High Risk with 16 and 18 Genotyping (No Pap)

Indications for Pap Smear (Information Required:

- ☐ Routine ICD-10/Dx _____
- ☐ High Risk ICE-10/Dx_____
- ☐ Diagnostic ICD-10/DX _____

Medicare ABN on file
☐ YES ☐ NO

PATIENT HISTORY (Check all That Apply)

- ☐ Abnormal Pap-Date_____Result:
- ☐ Repeat Pap ☐ Post-Menopausal ☐ Chemotherapy
- ☐ Pregnant ☐ Hormone Therapy ☐ Radiation
- ☐ Post-Partum ☐ Depoprovera ☐ Pap with biopsy
- ☐ Hysterectomy ☐ Abnormal Bleeding

BODY FLUID

- ☐ Source:_____

Place Patient Label Here

Place Accession Label Here

REQUIRED INFORMATION - COMPLETE ALL ITEMS

PLACE OF SERVICE (pos):_____

SPECIMEN DATE:_____

PATIENT NAME:_____
LAST FIRST MI

☐ M ☐ F DOB ____/____/____ SSN #_____

Ordering Provider:_____
LAST FIRST MI (Or Circle from List)

Supervising MD_____
LAST FIRST MI (Required for PA/NP orders)

BILL TO: ☐ PATIENT/PATIENT INSURANCE ☐ Client Account

RESPONSIBLE PARTY:
LAST FIRST MI

RELATION TO PATIENT:
☐ Self ☐ Spouse ☐ Dependent ☐ Other: PHONE ( )

STREET ADDRESS:
PO BOX, R.R.

CITY STATE ZIP

☐ Primary
MEDICARE # ☐ Secondary

MEDICAID # STATE

INSURANCE PLAN NAME: CITY/STATE

NAME OF POLICYHOLDER: DOB:

POLICY #: GROUP #

EMPLOYER OF POLICYHOLDER:

When ordering tests for which Medicare reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. Medicare will only pay for a screening PAP every two years, the patient is required to sign an ABN. A diagnostic PAP may be ordered once every twelve months if the PAP is associated with one of the risk factors. An appropriate ICD-10 code and risk factor must be specified for a diagnostic PAP. REQUEST FOR TESTING INDICATES PATIENT CONSENT TO RELEASE INFORMATION REGARDING TESTING AS REQUESTED IS ON FILE AT CLIENT FACILITY.
PLEASE ATTACH COPIES OF INSURANCE CARDS (FRONT AND BACK VIEW)

SURGICAL PATHOLOGY

TISSUE SOURCE _____
INFORMATION _____

TISSUE SOURCE _____
INFORMATION _____

TISSUE SOURCE _____
INFORMATION _____

TISSUE SOURCE _____
INFORMATION _____

REQUESTED TESTING:

- ☐ Microbiology Testing
  - ☐ Bacterial Culture ☐ Fungal Culture ☐ AFB Culture
- ☐ Gross and Microscopic Exam
- ☐ Gross Only
- ☐ Bone Marrow
- ☐ Surgical Slide Consultation (Outside slides and/or blocks)
- ☐ Blood Smear Consultation
- ☐ Breast Biopsy-Reflex testing to be conducted if biopsy is positive
  Reflex requires documentation on patient chart
  Breast Biopsy Reflex tests:
  - ☐ ERA/PRA
  - ☐ DNA (S Phase & Ploidy)
  - ☐ HER-2 NEU (Immunoperoxidase)
  - ☐ HER-2 NEU (FISH)