

**CYTOPATHOLOGY REQUISITION**

<b>Patient Information - PLEASE PRINT or use printed label</b>	<b>Billing Information:</b>
Medical Record #	<b>*Please list or attach the following insurance information:</b>
Patient SS# (optional)	Ins. Company Name
Patient Name	Ins. Co. Address
Birthdate Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	City/State/Zip
Patient Address	Policy # Group #
Phone # (H) (W)	Patient Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Physician	Insured's Employer
Copy To	Insured's Name
Order Date/Initials Account Code	Insured's Bithdate Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Bill to:</b> <input type="checkbox"/> Account <input type="checkbox"/> Medicare* <input type="checkbox"/> Medicaid*	Insured's Address(if not patient)
<input type="checkbox"/> Insurance* <input type="checkbox"/> Patient	City/State/Zip
	Does patient have other insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes-Send Info

**GYN Specimen**

**Sample Date:** \_\_\_\_\_

SPECIMEN SOURCE: (Select One)

- Cervical/Endocervical Combined
- Vaginal Only
- Endocervical Only
- Vulvar Lesion
- Other \_\_\_\_\_

TESTS: (Select One)

- Liquid based pap test with reflex high risk HPV if ASCUS
- Liquid based pap test with reflex high risk HPV testing for ASCUS or SIL
- Liquid based pap test AND high risk HPV test ("Cotest")
- Liquid based pap test only
- HPV test only

**Clinical Information and History:**

- LMP Date** \_\_\_\_\_  Postmenopausal **Previous Abnormal Pap Date:** \_\_\_\_\_
- Pregnant Currently  Cryosurgery  Oral Contraceptives
  - Postpartum  LEEP  Hormone Replacement
  - Abnormal Bleeding  Chemotherapy
  - Hysterectomy  Check if Supracervical  Radiation Therapy  Other: \_\_\_\_\_
  - IUD Present  DES Exposure

**Select Reason for Testing and ICD-9 Code(s)**

**Screening (B08)**

*Select if no symptoms of disease are present*

- V72.31 Routine Gynecological Examination/ V76.2 if Medicare
- V76.2 Special Screen for malignant neoplasm-cervix
- V76.47 Special Screen for malignant neoplasm-vagina
- V22.1 Supervision of other normal pregnancy

Other: \_\_\_\_\_

**Diagnostic (B09)**

*Use if signs or symptoms present, confirmed disease state, or previous abnormal*

- 795.00 Abnormal glandular Pap smear of cervix
- 622.11 Mild Dysplasia of cervix
- 622.12 Moderate dysplasia of cervix

Other: \_\_\_\_\_

**If Medicare, did patient sign an ABN?**  No  Yes

**NON-GYN Specimen**

**Date of Sample:** \_\_\_\_\_

**ICD-9 Code(s):** \_\_\_\_\_

SOURCE:

- Urine, voided
- Urine, Instrumented
- Sputum
- Fluid \_\_\_\_\_

- FNA \_\_\_\_\_
- Other \_\_\_\_\_

CLINICAL HISTORY:

