The Pathology Center

8303 Dodge Street Omaha, Nebraska 68114-4199
Phone: 402-354-4541; 888-432-8980 Fax: 402-354-8806
www.thepathologycenter.org

For Laboratory Use:

Place patient label here

Place accession label here

REQUIRED INFORMATION – COMPLETE ALL ITEMS

SPECIMEN DATE: _____
LEGAL PATIENT NAME: ☐ INPATIENT ☐ OUTPATIENT
LAST _____ FIRST _____ MI ____
☐ M ☐ F DOB ___/___/___ SSN# _____
Ordering Provider/Surgeon:
LAST _____ FIRST _____ MI ____
Supervising MD:
LAST _____ FIRST _____ MI ____
Copy to:
LAST _____ FIRST _____ MI ____

BILL TO: ☐ PATIENT/PATIENT INSURANCE ☐ CLIENT ACCOUNT

*** ATTACH COPIES OF ALL CURRENT INSURANCE CARDS ***

RESPONSIBLE PARTY:
LAST FIRST MI
RELATION TO PATIENT:
☐Self ☐Spouse ☐Parent ☐Other: PHONE ( )
STREET ADDRESS
P.O. Box, R.R.
CITY STATE ZIP
☐Primary
MEDICARE # ☐ Secondary
MEDICAID # STATE
INSURANCE
PLAN NAME: CITY/STATE
NAME OF
POLICY HOLDER DOB:
POLICY # GROUP #
EMPLOYER OF
POLICY HOLDER:
ADDITIONAL INSURANCE:

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. In the even the patient has more than one screening PAP in 2 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 & back view)**

LAB COPY 1

CYTOLOGY

PAP SOURCE: ☐ Cervical/Vaginal ☐ Cervical ☐ Vaginal
LMP Date: ___/___/___

☐ PAP Smear (Conventional glass slide)

OR

☐ Liquid Based Pap No HPV Testing

OR

☐ Liquid Based Pap and **reflex** HPV High Risk with 16 and 18 Genotyping (HPV testing for ASCUS and AGUS diagnoses)

OR

☐ Liquid Based Pap and **co-test** HPV High Risk including 16 and 18 Genotyping

OR

☐ HPV High Risk with 16 and 18 Genotyping (No Pap)

Indications for Pap Smear (Information Required):

☐ Routine ICD-10/Dx _____
☐ High Risk ICD-10/Dx _____
☐ Diagnostic ICD-10/Dx _____

Medicare ABN of file
☐ YES ☐ NO

PATIENT HISTORY (Check All That Apply)

☐ Abnormal PAP – Date:_____ Result:_____

☐ Repeat Pap ☐ Pregnant ☐ Post Partum
☐ Post Menopausal ☐ Hormone Therapy ☐ Depoprovera
☐ Chemotherapy ☐ Radiation ☐ Pap with biopsy

BODY FLUID

☐ Source: _____

SURGICAL PATHOLOGY

TISSUE SOURCE:

Clinical History (Pre-Op/Post-Op Findings):

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)

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LAST FIRST MI
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☐Self ☐Spouse ☐Parent ☐Other: PHONE ( )
STREET ADDRESS
P.O. Box, R.R.
CITY STATE ZIP
☐Primary
MEDICARE # ☐ Secondary
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☐ Post Menopausal ☐ Hormone Therapy ☐ Depoprovera
☐ Chemotherapy ☐ Radiation ☐ Pap with biopsy

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