The Pathology Center

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

D R O 0 0 7

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 treawetment of a patient, rather than for screening purposes. Medicare will only pay for a screening PAP every two years. In the event the patient has more than one screening PAP in 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-9 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)

CLIENT 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 with 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 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: _____

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)