Cytology / Pathology Form

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FOR LAB USE ONLY

AP 01001

CLIENT INFORMATION

Patient Last Name | First Name | MI | DOB MM/DD/YEAR | Age | Sex ☐M ☐F | Social Security # – –

Patient Home Address | Apt.# | City | State | Zip | Home Phone ( ) -- | Alternative Phone ( ) --

Bill To: ☐ Client * ☐ Patient ☐ Insurance ☐ Medicare (ABN) signed ☐ Medi-Cal (Attach POE) ☐ Work Comp ☐ HMO/IPA Authorization Number: _____

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent ☐ Other _____

Primary Ins. Name _____ ID# _____ Group # _____

Secondary Ins. Name _____ ID# _____ Group # _____

Employer's Name _____ City _____ Tel ( ) -

Please attach front and back copies of insurance card(s).

Patient's Reference ID:

Ordering Physician's Name:

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDI-CAL (MEDICAID) REIMBURSEMENT IS SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT, RATHER THAN FOR SCREENING PURPOSES.

COLLECTION INFORMATION

Collection Date: ____/____/____ Time: ____:____ AM PM # of Vials: ____

ICD-9/10 Code/DX 1 | ICD-9/10 Code/DX 2 | ICD-9/10 Code/DX 3 | ICD-9/10 Code/DX 4

* TANNER BILL (AB 474) & (AB 2544) PROHIBITS CLIENT BILLING FOR PAP SMEAR & MALDONADO (SB 661) PROHIBITS CLIENT BILLING FOR PATHOLOGY SERVICES.

GYNECOLOGICAL CYTOLOGY

CYTOLOGY TESTS

- ☐ Liquid-based Pap with Imaging
- ☐ Liquid-based Pap
- ☐ Conventional Pap

MOLECULAR TESTS

- ☐ HPV High Risk Amplified DNA
- ☐ HPV High & Low Risk Amplified DNA
- ☐ HPV - Reflex IF Ascus and Above
- ☐ HPV - Reflex IF Ascus
- ☐ Chlamydia Amplified DNA
- ☐ Gonorrhea Amplified DNA
- ☐ Chlamydia/GC Amplified DNA
- ☐ Herpes Simplex 1 DNA
- ☐ Herpes Simplex 2 DNA

CLINICAL INFORMATION / INDICATION

- ☐ Routine/Annual Pap
- ☐ Pregnant
- ☐ Post-Partum
- ☐ Abortion
- ☐ Contraceptives
- ☐ IUD
- ☐ Depoprovera
- ☐ Postmenopausal
- ☐ Hysterectomy
- ☐ Partial Hysterectomy (pt has CX)
- ☐ Radiation Rx
- ☐ Abnormal Bleeding
- ☐ Other: _____

Previous Pap: ____/____/____ Result: _____

LMP ____/____/____

SOURCE

- ☐ Cervix
- ☐ Endocervix
- ☐ Vaginal
- ☐ VCE
- ☐ Other: _____

Label slides in pencil with patient's name. State and Federal regulations require the above information to be complete.

SURGICAL PATHOLOGY/HISTOPATHOLOGY

Prior BX or Pap Date: ____/____/____ **Result:** _____

Biopsy Site(s)	Pertinent Clinical History (ICD-9 Code Required)
1)	
2)	
3)	
4)	
5)	
6)	

☐ **POC (Product of Conception)**

NON-GYNECOLOGICAL CYTOLOGY SOURCE

- ☐ Urine ☐ Voided ☐ Catheterized
- ☐ Thyroid FNA ☐ Right ☐ Left ☐ Sputum
- ☐ Breast FNA ☐ Right ☐ Left ☐ Washing Source _____
- ☐ Nipple Discharge ☐ Right ☐ Left ☐ Brushing Source _____
- ☐ Other: _____ ☐ Rectal/Anal
- _____ ☐ FNA Source _____

CLINICAL IMPRESSION / INSTRUCTIONS

Additional testing may be performed if determined to be medically necessary to render a diagnosis in the opinion of the reviewing pathologist at additional cost.

Physician's Signature: _____

Date: ____/____/____

AP 01001 (1)	AP 01001 (2)	AP 01001 (3)
AP 01001 (4)	AP 01001 (5)	AP 01001 (6)