SHARED REQUISITION - MICROBIOLOGY AND CYTOLOGY

LABORATORY ALLIANCE
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FOR LAB USE ONLY

ACCOUNT NO.	REQ. PREP. BY:
MEDICAL RECORD NO.	CYTOLOGY NO.

SPECIMEN INFORMATION

DATE COLLECTED	COLLECTED BY

COPY TO PHYSICIAN _____
FIRST NAME LAST NAME

PHYSICIAN'S SIGNATURE REQUIRED

_____

PATIENT INFORMATION

PATIENT NAME (LAST/FIRST/MI)

PATIENT I.D. NO.	SOCIAL SECURITY NO.

PHONE NO.	DATE OF BIRTH	SEX
		❑ MALE ❑ FEMALE

STREET ADDRESS

CITY, STATE, ZIP

INSURANCE BILLING INFORMATION

RESPONSIBLE PARTY (SUBSCRIBER)

SUBSCRIBER SOCIAL SECURITY NO.

PATIENT RELATIONSHIP TO INSURED
❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER _____

SUBSCRIBER'S ADDRESS (CITY/STATE/ZIP)

PRIMARY INSURANCE: CO. NAME

POLICY NO.	GROUP NO.

SECONDARY INSURANCE: CO. NAME

POLICY NO.	GROUP NO.

CYTOLOGY

GYN CYTOLOGY:

❑ **Reflex to High Risk HPV Testing if Results of PAP are ASCUS**
❑ **High Risk HPV Testing Requested with PAP**

Biopsy Taken? ❑ Yes ❑ No **LMP DATE** _____
Last Smear Date _____
Result _____

❑ Pregnant ❑ Post Partum ❑ Endocrine Rx ❑ IUD
❑ Chemotherapy ❑ Radiation ❑ Infectious Disease ❑ Post Menopausal
Other History: _____

PAP SMEAR SOURCE:
(Check all that apply)
❑ Vaginal
❑ Cervical
❑ Endocervical

PAP SMEAR TYPE:
(Check only one)
❑ Sure Path Pap
❑ Thin Prep Pap
❑ Conventional Pap
____ No. of Slides Submitted

PAP SMEAR INDICATION:
❑ Screening
❑ Diagnostic

Please complete ICD10 code box below.

MISC. CYTOLOGY: *(For Urine Specimens the following must be completed)*

Specify Source _____

❑ Voided ❑ Catheterized ❑ Wash ❑ Brush

Irritative Voiding Symptoms? ❑ Yes ❑ No		Microhematuria? ❑ Yes ❑ No	
Previous Tumor? ❑ Yes ❑ No		Urinary Diversion? ❑ Yes ❑ No	
Recent Chemotherapy? ❑ Yes ❑ No		Cystoscopy Done Recently? ❑ Yes ❑ No	
Radiation Therapy? ❑ Yes ❑ No		If Yes, Abnormal? ❑ Yes ❑ No	
Previous Urologic Surgery? ❑ Yes ❑ No		Biopsy Taken? ❑ Yes ❑ No	
Nephrolithiasis ❑ Yes ❑ No			

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❑ FNA Rapid Adequacy:

_____

_____

Gross Description:

_____
PATHOLOGIST SIGNATURE / DATE / TIME

MICROBIOLOGY

[ ] GC / Chlamydia, Amplified (GCCAT)
Source: _____
[ ] Grp A Strep Molecular (GASM)
Source: _____
[ ] Grp B Strep by PCR (BSBP)
Source: _____
[ ] Gram Stain Only (GRAM)
Source: _____

[ ] Herpes Simplex Viral Culture (HSVC)
Source: _____
[ ] Vaginitis DNA Probe / Affirm (VAGDT)
Source: _____
[ ] Throat Culture (THRC)
Source: _____
[ ] Urine Culture (URNC)
Source: [ ] Void [ ] Cath

[ ] OTHER Micro, Specify: _____
_____

ICD10 DX CODE(S) FOR TESTS ORDERED *(MUST BE PROVIDED)*

CYTOLOGY COPY