

REQUIRED PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Sex M F Patient I.D. _____

SSN _____ Phone (____) _____

Bill To: Our Account (No further information is needed)
 Patient Insurance (The following must be completed or your account will be billed)

Previous Names Used By Patient:

Patient's Marital Status (circle one): S M D W

Responsible Party

Name _____

Address _____

City _____ State _____ Zip _____

SSN _____ Relationship to Patient _____

Primary Insurance Information:

Insurance Co. Name _____

Address _____

Medicare Medicaid Insurance No. _____

Group No. _____

Primary Care Physician (If other than ordering Physician) _____

Secondary Insurance Information: Attach separate sheet

Check if this incident involves: Worker's Comp Litigation

Are ABN's, Referrals or Waivers needed for this billing? No Yes (Attach Copy)

Collection Date	Time	Status	Results
	A.M.	<input type="checkbox"/> Routine	<input type="checkbox"/> Call # _____
		<input type="checkbox"/> ASAP	
	P.M.	<input type="checkbox"/> STAT	<input type="checkbox"/> Fax # _____

Send copies of report to:

FOR LAB USE ONLY:

No. of Slides _____	Accession No. _____	Fin Class _____
No. of Specimens _____	Account No. _____	
Date Received _____		

REQUIRED DIAGNOSTIC INFORMATION

Tissue:

Pre-Operative **Diagnosis** _____

Post-Operative **Diagnosis** _____

Cytology:

Screening Pap Smear

Medically Indicated Pap Smear **Diagnosis**

Previous Smear Normal ASCUS Dysplasia or Worse

Date _____ Lab _____

TISSUE: (SURGICAL PATHOLOGY)

SPECIMENS:

A. _____ D. _____ G. _____

B. _____ E. _____ H. _____

C. _____ F. _____

GYN CYTOLOGY: (PAP SMEARS)

TESTS

- Liquid Based Prep (includes HPV DNA testing if final report of ASCUS)
 do **NOT** include HPV DNA testing
- Conventional Slide Prep
- Maturation Index (Vaginal Wall Only)

SPECIMEN TYPE

- Cervical
 Vaginal
 Vulvar
 Endocervical Brush
 Endocervical Aspirate
 Endometrial Aspirate
 Other _____

CLINICAL INFORMATION

- LMP _____
 Pregnant
 Post Partum
 Menopause
Hysterectomy Total
 Sub-total
- B.C. Pills
 Cone
 LEEP
 Cryo
 Laser
 Radiation
 Chemo
 Hormones _____
 Other _____

NON-GYN CYTOLOGY:

- Fine Needle Aspirate (Provide Details) _____
- Sputum Urine Fluid Other
- Spontaneous Voided Joint _____
 Induced Catheter CSF _____
 Post Bronchial Wash/Barbotage _____