CROUSE PATHOLOGY

LABORATORY ALLIANCE
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Cytopathology Requisition

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.

GYN CYTOLOGY:

❑ **Reflex to High Risk HPV Testing if Results of PAP are ASCUS**
❑ **High Risk HPV Testing Requested with PAP**
❑ **Reflex to HPV Genotype if HPV is Positive (Thin Prep Vial ONLY)**

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 ICD-10 code box below.

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

Specify Source _____

❑ Voided ❑ Catheterized ❑ Wash ❑ Brush

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

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

1.	2.	3.
4.	5.	6.

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❑ FNA Rapid Adequacy: _____

Gross Description:

PATHOLOGIST SIGNATURE / DATE / TIME