LABORATORY ALLIANCE
of Central New York, LLC
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Cytopathology Requisition

FOR LAB USE ONLY

ACCOUNT NO.

MEDICAL RECORD NO.

CYTOLOGY NO.

REQ. PREP. BY:

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.

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❑ FNA Rapid Adequacy: ______________________

Gross Description:

PATHOLOGIST SIGNATURE / DATE / TIME

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 ICD-9 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.