Lakeland Health

A

Pathology/Cytology Request

Location

PATIENT INFORMATION		
Patient Name B	DOB	GENDER
Ordering (Submitting) Physician/Surgeon D		
Referring/Copy to Physician E		
Diagnosis/ICD-10 Codes F		

PRIORITY STATUS

- ☐ STAT(S) Results will be telephoned
- ☐ Call: (C) 24 hours a day
- ☐ Call: (W) Business hours only C
- ☐ Fax: (F) _____

BILLING INFORMATION: MUST SUBMIT COPY OF PATIENT INFO SHEET & INSURANCE CARD

Bill to: ☐ Patient ☐ Medicaid ☐ Medicare ☐ Insurance ☐ Blue Cross ☐ Other (Name): G

A WRITTEN ORDER AND AN APPROPRIATE DIAGNOSIS MUST ACCOMPANY EACH LABORATORY TEST. WHEN ORDERING TESTS, FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, ONLY MEDICALLY NECESSARY TESTS FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT SHOULD BE ORDERED. *LIMITED COVERAGE REQUIRES ABN FOR MEDICARE PATIENTS.

Gynecological Cytology (Pap Test)

SPECIMEN INFORMATION

Collection Date	Collection Time M	Initials

☐ **Pap, ThinPrep Screening**
Routine screening for the early detection of cancer.
*Frequency limitations by Medicare require an abnormal. N

☐ **Pap, ThinPrep Diagnostic**
Patient had previous abnormal tests or has significant complaint related to the female reproductive system.

Additional Tests: (to be run from ThinPrep vial)

☐ **High Risk HPV**
Routine testing recommended only for women 30 years or older.

☐ **Reflex HPV if ASCUS only**
Reflex testing recommended only for women 21 years or older.

Physician Signature: H _____ Date: _____

Gynecological Source:
- ☐ Cervical/Endocervical
- ☐ Vaginal Specimen O

Last Menstrual Period (Required): _____

Clinical History (Required): P
- ☐ Normal History
- ☐ Hysterectomy, cervix remains
- ☐ Hysterectomy, cervix removed
- ☐ Menopausal ☐ Postmenopausal
- ☐ Pregnant ☐ Postpartum

Other:

☐ Surgical Pathology OR ☐ Nongynecological Cytology

(Please Check Appropriate Box)

Collection Date	Collection Time I	Time in Formalin: J	Initials	Frozen Section ☐ Yes ☐ No	Receive Time:	Time Called:

Specimen/Source: (Specimen descriptions should exactly match specimen label)

1. _____ L
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Total # of specimens submitted: _____

Physician Signature: H _____ Date: _____

Clinical diagnosis/history: K _____

Operation: _____

Inpatient Identification

LEGEND

The Pathology/Cytology Request contains the information necessary for both testing and billing purposes. ***Incomplete requisitions often cause delays in testing until we obtain complete or correct information. Please help us process your test requests quickly and accurately by completely filling out the test requisition.***

Following are examples of important portions of the requisition:

A. ***Facility/Physician Name:*** This section determines where the patient test results are directed. In some instances, this section will be pre-printed with the facility name. **If this is incorrect, please indicate where the test results should be directed.**

B. ***Patient Information:*** ALL of the patient information is required for correct identification. Use full names, avoiding the use of "nicknames." Include Maiden Name if available. The Date of Birth is **essential** for our hospital computer to assign a medical record number to the patient, for determining age-related test reference ranges, and to provide a second form of patient identification.

C. ***Priority Status:*** In order to address patient care needs, testing priorities have been defined. These include STAT, Fax, and Call during business hours.

D. ***Ordering Physician:*** Indicate the first and last name of the ordering physician.

E. ***Referring/Copy to Physician:*** Indicate the first and last name of the physician.

F. ***Diagnosis/ICD10 Code:*** This information is critical for accurate billing. Please provide an accurate diagnosis, or primary symptom the patient is experiencing for care.(e.g. "chest pain", "fatigue", "anemia", etc.). The term "rule out" is no longer an acceptable diagnosis code. Due to recent changes in Medicare reimbursement and regulations regarding medical necessity of laboratory tests, it is imperative that accurate diagnoses are recorded on the Outpatient Requisition, as this is the only way such information is relayed to the laboratory.

G. Billing Information: Due to state regulations, the facility performing laboratory tests must directly bill Medicare/Medicaid patients. Lakeland directly bills all major medical insurances companies. In all cases, all of the information in the "Billing Information" area is mandatory.

H. Physician Signature: Due to state and federal regulations, a valid written signature must accompany any laboratory test request.

For Surgical Pathology OR Nongynecological Cytology, please complete the following sections:

I. Collection Date/Time and Initials: Our accrediting agencies require documentation of the date and time of collection, as well as the initials of the person who collected the specimen.

J. Time In Formalin: Enter time formalin was added to specimen.

K. Clinical Diagnosis/History and Operation: Clinical diagnosis is a mandatory information field. Incomplete clinical information may cause undue delays in specimen processing. **NOTE:** Please include the procedure performed as well.

L. Specimen/Source: If non-gynecological specimen/tissue is being sent, please indicate the source. **CLEARLY LABEL** each specimen container with the appropriate specimen description and source. Describe in detail what is in each of the labeled vials. Improperly labeled containers may be cause for specimen rejection. **ALSO, indicate total number of specimens submitted.**

For Gynecological Cytology (Pap Test), please complete the following sections:

M. Collection Date/Time and Initials: Our accrediting agencies require documentation of the date and time of collection, as well as the initials of the person who collected the specimen.

N. Test: Check appropriate test - PAP, Thin Prep Screening or Diagnostic. Indicate if HPV or Reflex HPV is desired by checking the appropriate box.

O. Last Menstrual Period and Gynecological Source: This information IS REQUIRED. Please provide the patient's last menstrual period. Check appropriate source - cervical, vaginal or endocervical.

P. Clinical History: Clinical history information is CRITICAL to ensure appropriate diagnostic value. This information is also used in assurance of proper follow up and billing purposes.