Marshfield Labs™

Cytology Test Requisition

Patient Information

Last name	First	MI
Address	DOB	Sex ☐ M ☐ F
City	State	ZIP
Your patient ID number		

Medical necessity notice: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

Insurance Billing Information *(Attach card or face sheet)*

Patient status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital patient

Hospital discharge date ____ /____ /____

Primary: ☐ Medicare ☐ Medicaid ☐ Non-hospital patient

☐ Other ins. ____________________ ☐ Self ☐ Spouse ☐ Child

Subscribers last name	First	MI

Beneficiary/Member #	Group #

Claims address	City	State	ZIP

Secondary: ☐ Yes ☐ No *(If yes, attach)* ABN: ☐ Yes ☐ No

Diagnosis code *(required)* ICD-10 codes 1. ________ 2. ________ 3. ________

Client Information

Client name

Address

Account #

Bill to: ☐ Client/Provider ☐ Insurance

Ordering Provider

Provider name

☐ Call results to phone # _____-_____-________

☐ Fax report to # _____-_____-________

Specimen Information

Collection date (m/d/y)	Time

Cytology – GYN

Reason for testing – check (✔) one:

☐ Screening: PAP ICD# or Dx ____________________

☐ Diagnostic Pap ICD# or Dx ____________________

Orders – Liquid Prep Paps:

☐ Liquid prep

☐ Liquid prep & HPV, if ASCUS

☐ Liquid prep & HPV w/Genotyping, if ASCUS

☐ Liquid prep & HPV, if ASCUS or higher

☐ Liquid prep & HPV w/Genotyping, if ASCUS or higher

☐ Liquid prep w/HPV

☐ Liquid prep w/HPV & Genotyping

☐ HPV only (not recommended for primary screening

☐ Chlamydia, NAM

☐ Gonorrhea(GC), NAM

☐ Chlamydia & GC, NAM

☐ Trichomonas, NAM

Specimen Source:

☐ Cervical – Vaginal ☐ Vaginal only

History (first day of last menstrual period ______________):

☐ Regular ☐ Irregular ☐ Spotting

Pregnant (exp. delivery date __________)	☐ Yes	☐ No
Postpartum	☐ Yes	☐ No
Post-menopausal (age of menopause ________)	☐ Yes	☐ No
Birth control (type ___________)	☐ Yes	☐ No
IUD	☐ Yes	☐ No
Hormone therapy (type ___________)	☐ Yes	☐ No
Gross lesion	☐ Yes	☐ No
Previous dysplasia	☐ Yes	☐ No
Previous positive HPV test	☐ Yes	☐ No
Previous cancer (site ________________)	☐ Yes	☐ No
Surgery (type ________________)	☐ Yes	☐ No
Irradiation (completion date __________)	☐ Yes	☐ No

Cytology – NON GYN

Orders:

☐ Bile duct brushing

☐ Body cavity fluid (source ______________________________)

☐ Breast cyst fluid*

☐ Breast nipple secretion

☐ Bronchial brushing*

☐ Bronchial lavage (BAL)*

☐ Bronchial washing*

☐ CSF

☐ Esophageal brushing*

☐ Peritoneal washing

☐ Sputum*

☐ Urine (collection type ______________________________)

☐ Other ______________________________

*Number of specimens submitted if greater than 1 ______________

Clinical Impression/History: ______________________________

Special Requests: ______________________________

Cytology – Fine Needle Aspiration *(with or w/o core needle biopsy)*

Anatomic site: ______________________________

Procedure: ______________________________

Lesion size: ______________________________

Clinical impression: ______________________________

Special requests: ______________________________

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