CYTOLOGY REQUISITION

Marshfield Labs
A division of Marshfield Clinic
MARSHFIELD, WI 54449 • 800-222-5835

Ct. No.

Your ID No.

C000000

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GREAT MEDICINE CLINIC
123 MAIN STREET
ANYWHERE, USA 11111
(555) 123-4567 R0000R
GRTDOC ( )

☐ DOCTOR DR MD
☐ DOCTOR DOCTOR MD
☐ DOCTOR DOC MD

Name (Last, First, Middle Initial) | Date of Birth / / | Sex M F

Maiden/Previous Name | Responsible Party

Social Security Number

Patient Address

City | State | Zip

1

Collection Date / / | Collection Time ☐ AM ☐ PM | ***Patient Place of Service (must be completed)***
☐ Hosp Inpt (21) ☐ Hosp Outpt (22) ☐ Ambulatory Surg Ctr (24)
☐ Phy Office (11) ☐ Other _____

Medicare No./R.R. Medicare No. | Medicaid No.

If Medicare, Medicaid, or Railroad Retiree, complete Advance Beneficiary Notice (ABN), when necessary. See back of pink copy for details. Patient must sign, date and receive a copy of the ABN. ABN (waiver) sent? Yes___ No___

Provider Signature: _____ Date: _____

CYTOLOGY — GYN

REASON FOR TESTING: (check one)

☐ **Screening: Not at High Risk**
ICD # or Dx. _____

☐ **Screening: High Risk**
ICD # or Dx. _____

☐ **Diagnostic Pap**
ICD # or Dx. _____

ORDER:

Conventional paps:
( ) One Slide Pap
( ) Two Slide Pap
( ) Maturation Index

Thin Prep Paps
( ) Thin Prep Pap
( ) Thin Prep Pap & HPV, if ASCUS
( ) Thin Prep Pap & HPV
( ) HPV only (**NOT recommended for screening purposes**)

2

_____
Additional test to add to Thin Prep Pap
( ) Chlamydia, NAM
( ) GC, NAM
( ) Chlamydia/GC, NAM

SPECIMEN SOURCE:

☐ Cervical-Vaginal 84/317
☐ Cervical only 84/311
☐ Vaginal only 84/318
☐ Other; specify: _____

HISTORY: Date of last menstrual period: _____
☐ Regular ☐ Irregular ☐ Spotting

YES	NO	
		Pregnant; exp. delivery date _____
		Post Partum
		Post-Menopausal; age of menopause _____
		Birth Control; type _____
		I.U.D.
		Hormone Therapy; type _____
		Gross Lesion
		Previous Dysplasia
		Previous Positive HPV test
		Previous Cancer; site _____
		Surgery; type _____
		Irradiation; completion date _____
		Previous Abnormal Pap; result _____

CYTOLOGY — NON GYN

Diagnostic ICD # or Dx. _____

_____

☐ Call Results:

ORDER:

139/	☐	Body Fluid; source _____
139/197	☐	Breast Fluids*
84/	☐	Breast Nipple Secretion Smear
138/21	☐	Bronchial Brushings*
144/21	☐	Bronchial Washings*
5/34	☐	CSF
138/197	☐	Esophageal Brushings*
73, 74/	☐	Fine Needle Aspirate; source _____
138/66	☐	Gastric Brushings*
144/58	☐	Peritoneal Washings
30/	☐	Sputum*
143/	☐	Urine; Collection type: _____
143/306	☐	Urine Hemosiderin
	☐	Other Source _____

*Number of Specimens Submitted if > 1: _____

CLINICAL IMPRESSION: _____

C000000
NAME
DATE

How To Complete a Test Requisition

1. Fill in all mandatory fields (pink shaded areas).
2. For the GYN and NON-GYN sections, check the appropriate "Reason for Testing" checkbox (GYN section) and/or ICD number or diagnosis, if known. Select the appropriate test order. Include specimen source/type and any pertinent history. Please note that the specimen container must have two forms of identification: patient name, birth date, and/or ID number, as well as the specimen type/site or specimen number.
3. Insert top copy of requisition form into the pocket of the biohazard bag. Keep a copy for your records. Place the sample in the zip lock compartment of the biohazard bag and assure that it is completely sealed.