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: _____

