



INTERSCOPE PATHOLOGY

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GYN CYTOLOGY / HPV TEST REQUISITION

PATIENT DEMOGRAPHICS

INSURANCE INFORMATION

PLEASE PRINT LEGIBLY

STATE AND FEDERAL REGULATIONS REQUIRE YOU TO PROVIDE THE FOLLOWING PATIENT INFORMATION AND TO PRINT THE PATIENT'S NAME ON THE SPECIMEN OR THE SLIDE. FAILURE TO DO SO MAY REQUIRE US TO RETURN THE SPECIMEN.

Date Collected: ____/____/____

Last Name: [Grid]

First Name: [Grid] Mid Initial: [Grid]

Male Female

SS#: [Grid] Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____

Fill out the address, date of birth and social security number, or include a copy of the patients drivers license.

I authorize the release of medical records necessary to process this claim. I authorize payment of medical benefits to Interscope Pathology or the staff Pathologists.

I understand _____ when _____

Please make sure you have the patient sign.

Did the patient sign the ABN? Is ABN attached?

Signature _____ Date _____

Patient and billing information must be provided.

TEST ORDER: HPV with Pap
 Conventional Pap Smear ThinPrep Pap Test

SPECIMEN SOURCE: Cervical Vaginal Endocervical Other, Specify _____

CLINICAL DATA: Date of LMP _____ Pregnant _____ Weeks Postpartum Postmenopausal BC Pills / Patch IUD

Hormone Replacement (Including Cream) Yes No DES Exposed Abnormal Bleeding Other High Risk Factors: _____

CLINICAL PROCEDURES: Cryo Laser Biopsy Cone D&C Radiation Total Hysterectomy Sub-Total Hysterectomy

PREVIOUS CYTOLOGY: Abnormal Normal Date: _____

CLINICAL IMPRESSION: _____

PERTINENT HISTORY: _____

Bill Ref. Lab. Bill Patient Bill Insurance

Guarantor Last Name: [Grid]

First Name: [Grid]

Date of Birth: ____/____/____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

You may attach a copy of the insurance card instead of filling out this section.

Address of Carrier: _____

City: _____ State: _____ Zip: _____

Phone #: (____) _____

Subscriber #: _____ Group #: _____

Medicare #: _____

COPY CARD AND ATTACH

Medi-Cal #: _____

COPY CARD AND ATTACH

RE-CALL DATE: _____

Chlamydia Gonorrhea

HPV Test If ASCUS/AGUS, Reflex HPV

Include the ICD 9

DIAGNOSIS: _____
ICD-9 CODE _____

.....FOR LAB USE ONLY.....

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> 88175 ThinPrep Imaging | <input type="checkbox"/> V72.31 Routine GYN | <input type="checkbox"/> 626.7 Postcoital Bleeding | |
| <input type="checkbox"/> 88141 Professional | <input type="checkbox"/> V76.2 Routine CVE | <input type="checkbox"/> 627.1 PM Bleeding | <input type="checkbox"/> S CODE: _____ |
| | <input type="checkbox"/> V76.47 Routine Vag | <input type="checkbox"/> 627.3 Atrophic Vag. | |
| <input type="checkbox"/> G0145 | <input type="checkbox"/> V22.2 Pregnant | <input type="checkbox"/> 795.00 AGUS NOS | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> G0124 | <input type="checkbox"/> V24.2 Post-partum | <input type="checkbox"/> 795.01 ASC-US | |
| | <input type="checkbox"/> V15.89 Other Specified Hx | <input type="checkbox"/> 795.02 ASC-H | |
| <input type="checkbox"/> 88164 Conventional | <input type="checkbox"/> 078.11 Condyloma | <input type="checkbox"/> 795.03 LGSIL | |
| <input type="checkbox"/> P3000 | <input type="checkbox"/> 233.1 CIN III/CIS | <input type="checkbox"/> 795.04 HGSIL | |
| <input type="checkbox"/> P3001 | <input type="checkbox"/> 616.0 Cervicitis | <input type="checkbox"/> 795.05 HPV | <input type="checkbox"/> ASB |
| | <input type="checkbox"/> 616.10 Vaginitis | <input type="checkbox"/> 795.08 Unsat. | <input type="checkbox"/> WJC |
| <input type="checkbox"/> 87621 High Risk HPV | <input type="checkbox"/> 622.10 Dysplasia | <input type="checkbox"/> 795.09 Other Abn. | <input type="checkbox"/> BTL |
| <input type="checkbox"/> GA ABN | <input type="checkbox"/> 626.6 Metrorrhagia | <input type="checkbox"/> V73.89 Other Viral | <input type="checkbox"/> GEM |

Pink: Lab Copy Canary: Billing White: Client