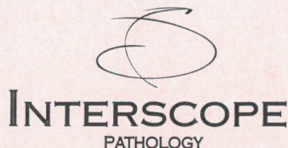

INTERSCOPE
PATHOLOGY

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Directors / Pathologists
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GYN CYTOLOGY / HPV TEST REQUISITION

Date Collected ____/____/____ Time Collected _______ AM / PM

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.

PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION:

Last Name:	First Name:	M.I.	LAST FOUR OF SS#:	DOB: (mm/dd/yyyy)
Street Address:	City:	State:	Zip:	Phone:

INSURANCE INFORMATION (Attach copy of card or fill in below:)

BILL TO ☐ PATIENT ☐ MEDICARE ☐ MEDI-CAL ☐ INSURANCE: ☐ Blue Cross • ☐ Blue Shield • ☐ Aetna • ☐ Other__________

Guarantor if other than patient:	DOB: (mm/dd/yyyy)	Street Address:	City:	State:	Zip:
Subscriber/Medicare/Medi-Cal #:	Group ID:				
Insurance Carrier Street Address:	City:			State:	Zip:

IF MEDICARE, PLEASE ATTACH ABN
I authorize release of medical records necessary to process this claim. I authorize payment of medical benefits to Interscope Pathology. I understand I am financially responsible for all charges incurred whether or not they are paid by Medicare or other insurance.

SIGNATURE:	Date:

NOTICE TO CUSTOMERS
Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 - www.mbc.ca.gov

TEST ORDER: ☐ HPV with Pap COTEST (>30 YRS OLD ONLY) ☐ Imaged ThinPrep Pap Test ☐ If ASCUS/AGUS, Reflex HPV (>21 YRS OLD ONLY) ☐ Reflex 16/18 (normal pap HPV+)

☐ SurePath Pap Test ☐ B-D Affirm Org. Screen ☐ HPV Test Aptima ☐ CT/GC Aptima Source other than TP: ☐ urine ☐ vaginal swab ☐ CT only ☐ Trichomonas Aptima

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: __________ Accession#: __________

CLINICAL IMPRESSION: __________ DIAGNOSIS: __________

PERTINENT HISTORY: __________ ICD CODE: __________

FOR LAB USE ONLY. PLEASE DO NOT WRITE BELOW THIS LINE

☐ 88175 Liquid Pap-Imaged	☐ Z01.419 Routine GYN	☐ N95.0 PM Bleeding	☐ Z85.3 Hx Breast CA
☐ 88142 Liquid Pap-Manual	☐ Z12.4 Routine CVE	☐ N95.2 Atrophic Vag.	☐ C50.919 Breast CA
☐ 88141 Professional	☐ Z12.72 Routine Vag	☐ N93.0 Postcoital Bleeding	☐ C53.9 Cervical CA
☐ GO145 TP	☐ Z34.90 Pregnant	☐ R87.619 AGUS NOS	☐ C54.9 Endometrial CA
☐ GO123 SP	☐ Z39.2 Postpartum	☐ R87.610 ASC-US	☐ C56.9 Ovarian CA
☐ GO124 Professional	☐ A63.0 Condyloma	☐ R87.611 ASC-H	☐ Z11.51 HPV Screening
☐ GA ABN	☐ N72 Cervicitis	☐ R87.612 LGSIL	☐ Z11.8 Chlamydia Screen
☐ 87624 High Risk HPV	☐ N76.0 Vaginitis	☐ R87.613 HGSIL	☐ Z09 F/U post treatment
☐ 87625 16/18 HPV	☐ N87.9 Dysplasia	☐ R87.810 HPV +	☐ Z11.3 VD Screen
☐ 87491 Chlamydia	☐ N88.2 Cervical Stenosis	☐ R87.615 Unsat.	☐ Other: __________
☐ 87591 N.gonorrhoeae	☐ N84.1 Cervical Polyp	☐ R87.618 Other Abn.	☐ WJC
☐ 87480 Candida	☐ N89.8 Vag Discharge	☐ Z85.41 Hx Cervical CA	☐ BTL
☐ 87510 Gardnerella	☐ N92.1 Metrorrhagia	☐ Z85.42 Hx Uterine CA	☐ IVK
☐ 87660 Trichomonas Direct			
☐ 87661 Trich Amplified			

Pink: Interscope Copy White: Client