GYN Pathology Requisition

Alliance Laboratories Southeast
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PATIENT INFORMATION

Last Name	First Name	
Address		Apt #
City	State	Zip Code
Phone	Sex	Age	DOB
Social Security #	Medical Record #	

COLLECTION INFORMATION

Date: ___/___/____ Time:

LAB USE ONLY

Case #: ______________________

Date Received: _____/_____/_______

Time Received: ______________

BILLING INFORMATION

Name of Insured		
Company Name		
Street Address		
City	State	Zip
Policy #	Group #	
Medicare/ Medicaid #	Referral #	

ACCOUNT INFORMATION

CLINICAL HISTORY

Check all that apply: ☐ Bilateral, tubal ligation ☐ Biopsy today ☐ Colposcopy ☐ Depo Provera ☐HRT Transgender
☐ Estrogen replacement therapy ☐ H/O abnormal pap ☐ H/O neoplasm ovary ☐ H/O neoplasm of cervix
☐ H/O neoplasm of vulva ☐ H/O neoplasm uterus/corpus uteri ☐ High glandular previous lesion
☐ Hormone ☐ Hysterectomy (Supracervical) ☐ Hysterectomy (Total or Radical) ☐ IUD ☐ Lactating ☐ Menopausal
☐ Menopausal/HRP ☐ Menopausal/Hysterectomy ☐ Oral contraceptives ☐ Post-menopausal ☐ Postpartum
☐ Pregnant ☐ Previous cone/LEEP ☐ Radiation/Chemotherapy ☐ Other: ____________________________________

Date of LMP
___/____/______

DATE OF LAST PAP: ____/____/________
PREVIOUS RESULTS: ☐NORMAL ☐REACTIVE ☐AGUS ☐ASCUS ☐LGSIL ☐HGSIL ☐ CIN1 ☐CIN2 ☐CIN3

GYN & ANAL CYTOLOGY

SPECIMEN SOURCE: ☐ Cervix ☐ Vagina ☐ Vaginal Cuff ☐ Endocervical ☐ Endometrial ☐ Anus

ThinPrep®:
☐ PAP Test
☐ HR HPV Screening (over 25)
☐ HR HPV Reflex/ASCUS
☐ HR HPV Requested ☐ Mycoplasma Genitalium
☐ Chlamydia & Gonorrhea ☐ Trichomonas Vaginalis

Aptima Multitest Swab
☐ Bacterial Vaginosis
☐ Candida glabrata & C group
☐ Chlamydia ☐ Mycoplasma Genitalium
☐ Gonorrhea ☐ Trichomonas Vaginalis
☐ HSV 1&2 ☐ OTHER: ______________________________

Common ICD10 codes (required):
Z34.80 ☐ Encounter for supervision of other normal pregnancy, unspecified trimester
Z36.85 ☐ Encounter for antenatal screening for Streptococcus B
Z12.4 ☐ Encounter for GYN screening of malignant neoplasm of cervix
Z10.411 ☐ Encounter for GYN examination/ abnormal findings
Z10.419 ☐ Encounter for GYN examination/ abnormal findings
Other: ____

NON-GYN CYTOLOGY

Specimen: Urine
Test(s) required. Please check box

☐Cytology + Bladder Ca + Chlamydia/Gonorrhea
☐Cytology + Bladder Ca
☐Cytology + Chlamydia/Gonorrhea
☐Cytology
☐Bladder Ca by FISH (VesicaDx)
☐Chlamydia/Gonorrhea

Other Fluid for Cytology

1.____________________
2.____________________
3.____________________

HISTOLOGY

Tissue Type	ICD-10
1.____________________	__________
2. ____________________	__________
3. ____________________	__________

Name: ___________	Name: ___________	Name: ___________	Name: ___________

Non-Medicare Patients: I hereby authorize Alliance Laboratories Southeast to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Alliance Laboratories Southeast & understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-authorized services. I permit a copy of this authorization to be used in place of the original

Patient/Responsible Party Signature: ____