DID YOU INCLUDE...
- **DIAGNOSIS CODE(S)?**
- **TEST(S) TO BE PERFORMED?**
- **PROVIDER FIRST/ LAST NAME?**
- **WHO TO BILL?**

CYTOLOGY OUTPATIENT REQUEST FORM

Providence
Alaska Medical Center
P.O. Box 196604 Anchorage, AK 99519-6604
CYTOLOGY (907) 212-3098
FAX (907) 212-4873

ORDERING PROVIDER SIGNATURE: _____

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED. USE BLACK OR BLUE INK ONLY

PATIENT'S FULL LEGAL NAME (REQUIRED) | FIRST: | MI:
LAST:

DATE OF BIRTH (REQUIRED):

SEX (REQUIRED): ☐ MALE ☐ FEMALE ☐ OTHER

☐ **STAT**
Phone: _____
Fax #: _____
☐ Fax Results Immediately

DIAGNOSIS ICD CODE(S) (REQUIRED):

ADDITIONAL COPIES TO:

BILL: ☐ **CLIENT/PHYSICIAN ACCOUNT #:_____ COMPLETE REQUIRED AREAS** ☐ **PATIENT BILL COMPLETE REQUIRED & AREAS BELOW** ☐ **INSURANCE COMPLETE ALL AREAS**

SUBSCRIBER (LAST, FIRST, MIDDLE) | DATE OF BIRTH

GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FOR MEDICARE) | DATE OF BIRTH

ADDRESS (CITY, STATE, ZIP)

ADDRESS | PHONE # | PATIENT RELATIONSHIP

CITY/STATE/ZIP CODE: | INSURANCE CO.

PT. RELATIONSHIP: | CLAIMS ADDRESS (CITY, STATE, ZIP)

HOME PHONE NO.: | WORK PHONE NO.: | INSURANCE PHONE | INSURANCE/MEMBER POLICY # | GROUP #

TODAY'S DATE (REQUIRED): | **COLLECTION DATE (REQUIRED):** | **COLLECTION TIME (REQUIRED):**

GYNECOLOGIC CYTOLOGY

SOURCE:
- ☐ CERVICAL
- ☐ VAGINAL
- ☐ ENDOCERVICAL

HPV testing includes screening for Genotype 16, 18 & 12 other High Risk variants.
- ☐ PAPLQ (LAB7091) - Pap Only (Liquid)
- ☐ PAPHP (LAB13438) - Pap+HPV (regardless)
- ☐ PAPACR (LAB13436) - Pap+Reflex to HPV if ASCUS
- ☐ PSHPV (LAB1793) Misc. HPV Primary Screen reflex enter test comment PAML test code PSHPV
- ☐ SLIDES _____ (Please indicate # of slides)
- ☐ GC/CHL by PCR (LAB1376) - Using Liquid Based Pap

One of the Following *Must* Be Checked (Required)
- ☐ Screening PAP
- ☐ Screening High Risk PAP
- ☐ Diagnostic PAP

(FOR MEDICARE SEE NOTICE ON REVERSE)

GYN HISTORY

LMP MM/DD/YY _____ (REQUIRED)

- ☐ Routine Exam
- ☐ Estrogen Therapy
- ☐ DES Exposure
- ☐ Oral Contraceptives
- ☐ Abnormal Bleeding
- ☐ Radiation
- ☐ Pregnant _____ wks
- ☐ IUD
- ☐ Chemotherapy
- ☐ Post Partum _____ wks
- ☐ History of Malignancy
- ☐ Gyn Biopsy
- ☐ Post Abortion
- ☐ Hysterectomy (total)
- ☐ Gyn Cone
- ☐ Post Menopausal
- ☐ Hysterectomy (cervix intact)
- ☐ Gyn Surgery

ABNORMAL PAP HISTORY: *(INCLUDE DATES)*

_____

NON-GYNECOLOGIC CYTOLOGY

- ☐ SPUTUM
- ☐ BRONCH. WASH: Lobe _____ ☐ LEFT ☐ RIGHT
- ☐ BRONCH. BRUSH: Lobe _____ ☐ LEFT ☐ RIGHT
- ☐ BAL Indicate Lobe _____
- ☐ PLEURAL (CHEST) FLUID ☐ LEFT ☐ RIGHT
- ☐ ASCITES (ABDOMINAL) FLUID
- ☐ URINE *(FRESH ONLY)*
- ☐ BREAST NIPPLE SECRETION ☐ LEFT ☐ RIGHT
- ☐ CSF
- ☐ OTHER _____
- ☐ BRUSHINGS SOURCE _____

FINE NEEDLE ASPIRATION
- ☐ BREAST ☐ LEFT ☐ RIGHT
- ☐ THYROID ☐ LEFT ☐ RIGHT
- ☐ LYMPH NODE SITE _____
- ☐ OTHER _____

MISCELLANEOUS

- ☐ PNEUMOCYSTIS STAIN (MICROBIOLOGY)
- ☐ URINE HEMOSIDERIN
- ☐ RECURRENT ASPIRATION PANEL (LIPID)
- ☐ TZANCK SMEAR
- ☐ OTHER _____

CLINICAL HISTORY

_____

LAB USE ONLY:

ACCESSION NUMBER: _____
MEDICAL RECORD #: _____
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MEDICARE PAP SMEAR NOTICE

Please Note: According to Medicare B guidelines, a screening pap smear can only be performed and reimbursed on beneficiaries once in a two year period; or whose attending physicians believe more frequent tests are necessary due to evidence that there are high risks of developing cervical cancer. Diagnosis codes must substantiate the above, or the beneficiary will be responsible for the balance in full. An Advance Beneficiary Notice must be signed if the beneficiary's testing exceeds Medicare's frequency limitations for Pap smear testing or if the diagnosis does not support a diagnostic Pap smear.

NOW OFFERING MORE SPECIMEN COLLECTION LOCATIONS TO SERVE YOU BETTER

Providence Health Park
3841 Piper Street, Suite T-211
Anchorage, AK 99508
Phone (907) 212-5815
Fax (907) 212-3632

Tudor Square
3425 E. Tudor Road
Anchorage, AK 99504
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