PATHOLOGY REQUISITION CYTOLOGY

PATIENT INFORMATION		Today's Date:
Last Name:	First Name:	M.I.:
Attending Physician:		DOB:
Ordering Physician (Please print):		
DIAGNOSIS:		
COPY TO:		

CLINICAL HISTORY:

LMP ___/___/____ ☐ UNKNOWN

☐ LAST PAP NORMAL
Approximate Date: ____/___/____

Mark All That Apply:
- ☐ Postmenopausal
- ☐ Pregnant
- ☐ Post-partum
- ☐ Total hysterectomy
- ☐ Partial hysterectomy
- ☐ Oral contraceptives
- ☐ Depo-Provera (medroxyprogesterone acetate)
- ☐ IUD
- ☐ Hormone Therapy: _____
- ☐ Abnormal bleeding
- ☐ Abnormal discharge
- ☐ Visible lesion/mass
- ☐ DES exposure
- ☐ Chemo / Radiation

PREVIOUS ABNORMAL HISTORY:

DATE: ___/___/____ ☐ UNKNOWN

Results:
- ☐ ASCUS
- ☐ LSIL
- ☐ HSIL
- ☐ Carcinoma
- ☐ High risk HPV

Biopsy Results: _____
DATE: ___/___/____

GYNECOLOGIC:

COLLECTION DATE: ____/____/____ COLLECTION TIME: _____

SOURCE:
☐ CERVICAL/ENDOCERVICAL ☐ VAGINAL ☐ OTHER: _____

PAP TEST:
- ☐ Pap with high risk HPV testing (reflex HPV 16, 18/45 genotyping if criteria are met), ages 30-65
- ☐ Pap with reflex high risk HPV testing on ASCUS/ASC-H, ages 21-29
- ☐ Pap only

ADDITIONAL TESTING:

☐ Chlamydia/ N. Gonorrhoeae (CT/GC)
- Sexually active women younger than 25 years
- Women 25 years and older with high risk factors

NON-GYN:

Collection Date: ___/___/____
Collection Time: _____
- ☐ Urine
- ☐ Pleural fluid
- ☐ Peritoneal fluid
- ☐ Other: _____

NON-GYN Clinical History:
_____
_____
_____

Volume submitted: _____ mL

ACOG CERVICAL CANCER SCREENING GUIDELINES (some exceptions apply to these guidelines)

Younger than 21 years old	▪ No screening
21-29 years old	▪ Pap test every 3 years
30-65 years old (three options)	▪ Pap test and an HPV test (co-testing) every 5 years ▪ Pap test alone every 3 years ▪ HPV test alone every 5 years
65 years and older	▪ No screening if there is no history of cervical changes and either three negative Pap test results in a row or two negative co-test results in a row within the past 10 years, with the most recent test performed within the past 5 years

LABORATORY USE ONLY: _____

_____

_____

Physician Signature: _____ Date: _____ Time: _____

Riverview HEALTH

PATHOLOGY REQUISITION CYTOLOGY

White – Medical Records Yellow – Laboratory

(Attach Patient Label Here)

PATHOLOGY REQUISITION CYTOLOGY

Responsible Party Name (if patient is a minor):	
Responsible Party Address and Phone:	
☐ Medicare #:	☐ Medicaid # (EDD):

☐ **PRIMARY INSURANCE** (Complete or attach a copy of insurance card)		
Insurance Company Name:		
Network:		
Claim's Address:		
City:	State:	Zip:
Policy Holder Name:		DOB:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent		
Policy ID #:	Group #:	
Employer:	Effective Date:	

☐ **SECONDARY INSURANCE** (Complete or attach a copy of insurance card)		
Insurance Company Name:		
Network:		
Claim's Address:		
City:	State:	Zip:
Policy Holder Name:		DOB:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent		
Policy ID #:	Group #:	
Employer:	Effective Date:	

FINANCIAL AGREEMENT

I hereby agree to pay Riverview Hospital and Physicians their charges for all services rendered during this hospitalization or medical treatment. I shall also be responsible for any attorney fees required to collect for these services to which may be added interest at the current legal rate. I hereby assign directly to Riverview Hospital and Physicians payment of my hospitalization and health insurance benefits applicable to this hospitalization and authorize the collection of such funds on my behalf by Riverview Hospital and Physicians. Such payments shall not exceed my balance owed to Riverview Hospital and Physicians**.**

I acknowledge that Emergency Room physicians, Hospitalists, Radiologists, Pathologists, and Anesthesiologists who participate in my care are independent contractors and not agents or employees of Riverview Hospital, and I will receive separate bills from their employers or billing companies. I also acknowledge and understand that other ancillary care providers who participate in my care may not be Riverview Hospital agents and/or employees.

I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for all charges not otherwise paid by assignment to insurance benefits. I also certify that any information I have given in applying for coverage under the Social Security Act, or any insurance or other information I have provided is true and correct.

If I provide Riverview Hospital or its agents with my cell phone number, I authorize Riverview Hospital or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe. I understand that any email I provide is my personal email and I authorize Riverview Hospital or its agents to contact me via that email address.

Signature of Responsible Party _____

Physician Signature: _____ Date: _____ Time: _____