Client: _____ Phone: _____ Address:_____

SSM Health
ST MARY'S
LABORATORY
SERVICES
700 S Park Street
Madison, WI 53715
608-258-6917

Name:_____

DOB __/__/____ Sex M F

Ordering Phys/Surgeon _____

Ordering Physician Address_____

Ordering Physician Contact Phone_____

FOR MEDICARE/MEDICAL ASSISTANCE PATIENTS PLEASE COMPLETE ADDRESS AND INSURANCE INFORMATION BELOW

(Patient Street Address)	(City)	(State)	(Zip)

Primary Ins. (MC/MA) Carrier	MC/MA #	Supplemental Ins. Carrier	Policy #	Group #

Medicare regulations mandate that a medical justification (ICD code) be assigned for each test requested. Please indicate an ICD code in the space provided below.

Date Of Surgery: _____

Pre-Op diagnosis (with ICD Code): _____

_____

Lab Use Only
Pathology
Case # Label

Specimen 1: _____

Specimen 2: _____

Specimen 3: _____

Specimen 4: _____

√	TEST NAME		√	TEST NAME
	Surgical Pathology			**Flow Cytometry**
	5130 Biopsy Tissue			5439 DNA Analysis
	5130 Frozen Section			6848 Leuk-Lymph Eval
	5130 Slide Consult			6843 T + B Cells Subset
	5400 Fine Needle Aspirate			5433 T Cell Lymph Subset
	5197 Slide Prep / Recut			5702 Chromosome Bone Marrow
				5128 Bone Marrow

Required Cytology Questions: **Source:** _____ **Diagnosis:** _____

Clinical History (circle) Abnormal Bleeding Chemotherapy Discharge Hormone Preplacement IUD

None Applicable Oral Contraceptives Postmenopausal Postpartum Pregnant Radiation

Previous Abnormal Pap: No / Yes Date: _____

Date Of Last LMP Known? Date_____ Unknown