St. Mary's Medical Center Department of Pathology P.O. Box 1628 Grand Junction, CO 81502-1628 (970) 298-2064 (Pathology)	*AD Long, MD* *RA LaCount, MD*	*HS Mooney, MD* *TL Marshall, MD*	CLIA ID # 06D0519294

SPECIMEN NUMBER: ______________________ **CODES:** ______________________

REQUESTING PHYSICIAN	PHONE	COPY TO	COLLECTION DATE	COLLECTION TIME

PATIENT AND BILLING INFORMATION (Please Print)

LAST NAME	FIRST NAME	INITIAL	PREVIOUS NAME	BIRTH DATE	SEX
ADDRESS	CITY	STATE ZIP	PHONE	SOCIAL SECURITY #	

Please provide complete billing information (demographic face sheet) and include insurance card copy.

INSURANCE SIGNATURE AUTHORIZATION

The undersigned directs payment to St. Mary's Medical Center and/or Grand Junction Pathologists, PC of any insurance benefits otherwise payable to or on behalf of the undersigned for laboratory services rendered. It is understood by the undersigned that he/she is financially responsible for the charges not covered by the insurance company. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at a rate of 1% per month (12% annum).

Signature of Financially Responsible Party: Date: Time:

GYNECOLOGICAL CYTOLOGY (Pap Smear)

- ☐ **ROUTINE SCREENING PAP SMEAR** (Asymptomatic patient)
- ☐ **DIAGNOSTIC PAP SMEAR** (Previous abnormal pap, high risk patient, or symptomatic patient)

Diagnosis Code(s)

GYN CYTOLOGY TESTS:

- ☐ ThinPrep Pap® Test
- ☐ ThinPrep Pap® Test with HPV DNA reflex testing ***if diagnosis is "ASCUS"***
- ☐ ThinPrep Pap® Test with HPV DNA **regardless of the diagnosis**
- ☐ HPV DNA Testing ***only***

SPECIMEN SOURCE:

- ☐ Cervical
- ☐ Vaginal
- ☐ Other ______________________

CLINICAL INFORMATION:

LMP ______ / ______ / ______

- ☐ Pregnant
- ☐ Postpartum
- ☐ Postmenopausal
- ☐ Hormones ______________________
- ☐ IUD Present
- ☐ Hysterectomy (cervix absent)
- ☐ Hysterectomy (cervix present)
- ☐ Abnormal bleeding

Previous Pap Smear:

Date: ______ / ______ / ______

Number/Diagnosis: ______________________

NON-GYNECOLOGICAL CYTOLOGY

SPECIMEN SOURCE: ☐ Sputum ☐ Urine ☐ Other: ______________ ☐ FNA, Source: ______________

CLINICAL HISTORY: ______________________

QS/QSDX *(Lab Use Only)*

HISTOLOGY / SURGICAL PATHOLOGY

SPECIMEN(S):

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CLINICAL INFORMATION:

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FS/FXDX *(Lab Use Only)*

Signature: ______________________ Date: ____________ Time: ____________

SCL Health
ST. MARY'S

0N080

PATIENT INFORMATION

Cytology & Surgical Pathology Requisition

White – Chart Yellow – Originator

3010330 Rev. 07/18