CYTOPATHOLOGY CONSULTATION REQUEST

DEPARTMENT OF PATHOLOGY

UNIVERSITY OF MARYLAND - ST. JOSEPH MEDICAL CENTER

7601 OSLER DRIVE
TOWSON, MARYLAND 21204
(410) 337-1735

FM-CYTOPTH

Please complete all Required Fields *

*PATIENT LAST NAME FIRST NAME	*INSURANCE
*DATE OF BIRTH RACE SEX PHONE LMP	*INSURANCE ADDRESS
*ADDRESS	*POLICYHOLDER *DATE OF BIRTH *RELATIONSHIP TO PATIENT
CITY STATE ZIP	*POLICY # *GROUP #
SOCIAL SECURITY # PRIMARY CARE PHYSICIAN	SECONDARY INSURANCE (Patient Medicare Secondary Payor Information Required)

****DIAGNOSIS /** and/or **ICD 10 CODES (must be provided)**

PHYSICIAN NOTICE When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, and each test requested must be accompanied by an appropriate written diagnosis or ICD-10CM code.

Medicare Insured Patients Advance Beneficiary Notice / Waiver Statement

Medicare will only pay for services that it determines to be "reasonable and necessary." If Medicare denies payment, I agree to be personally responsible for payment of all charges.

- ☐ **I have read, understand and accept the conditions of the Advanced Beneficiary Notice.**
- ☐ **I believe that I have already had a screening PAP Smear during the last 3 years.**
- ☐ **I believe that I have NOT already had a screening PAP Smear during the last 3 years.**

Signature of Patient or Responsible Party: _____ Date: _____

☐ **RUSH** ☐ **ROUTINE** ***Date Collected:** _____

Time Collected: _____ ☐ AM/☐ PM

OB/GYN (check each column appropriately)

Specimen Source	Test Requested	All Patients (Required)	Current History	Treatment or Surgery
☐ Vagina/Cervical	☐ PAP Smear only	☐ **Routine Screen**	**LMP: (Date)** _____	☐ Hysterectomy
	☐ PAP Smear with **reflex** HRHPV		☐ Pregnant	☐ Supracerv. hyst
☐ Vaginal		☐ **Diagnostic or**	☐ Abnormal Bleeding	☐ Chemotherapy
	☐ PAP Smear with HRHPV	**High Risk**	☐ Postpartum	☐ Radiation Therapy
☐ Other: _____	☐ Reflex HPV G-16, 18/45		☐ IUD	☐ Hormonal Therapy:
			☐ Oral Contraceptive	_____
	☐ Additional Tests:		☐ Postmenopausal	☐ Other History/Findings:
	☐ Chlamydia		☐ Abnormal cytology, biopsy:	_____
	☐ Gonorrhea		_____	_____
	☐ HSV I ☐ HSV II			
	☐ TV Trichomonas Vaginalis			

MED/SURG

☐ **Sputum:**	☐ Early Morning	☐ Post bronchoscopy	☐ Random		
☐ **Bronchoscopy:**	☐ Washing	☐ Brushing	☐ Bronchoalveolar lavage		☐ Site: _____
☐ **Urinary**	☐ Voided Urine	☐ Catheterized Urine			☐ Other: _____
☐ **Body Cavity Fluids**	☐ Pleural: ___L ___R	☐ Pelvic Washings	☐ Peritoneal	☐ Pericardial	☐ Other: _____
☐ **Breast ___L____R**	☐ Nipple smear	☐ Aspirate	☐ Cyst aspirate		
☐ **Fine Needle Aspiration.** (specify site) _____					
☐ **Other:** (specify)					

PERTINENT CLINICAL HISTORY:

PREVIOUS SURGERY / BIOPSY / CYTOLOGY

Cytology ACCN _____ Date Received in Lab _____ Tech _____ ***Requesting Physician (Print)** _____

***Signature** _____ **Date** _____ **Time** _____

FM-CYTOPTH (9/15)

SPECIMEN GROSS DESCRIPTION

PROCESSING: Time:_____ Date: ____ / _____ / _____ Tech:_____

MATERIAL: Amt: _____cc Fresh _____ Fixed: _____ Type Fix: _____

*Volume may reflect total of specimen, fixative and/or collection fluid.

Slides Rec'd:_____

APPEARANCE: Clear: _____ Cloudy _____ Foamy_____ Bloody _____ Clotted _____

Tissue _____ Color_____

PREP: Smear(s) _____ Diffquick_____ Filter _____ Cell block _____

Cytospins: Single_____ Double _____ H + E_____ Unstained _____

COMMENT:

GYN REPORT MENU

I. SPECIMEN TYPE

1 __VAG-CERV
2 __VAG
OTHER _____

II. ADEQUACY

#3 __ENDOCERVICAL COMPONENT CANNOT BE DETERMINED DUE TO ATROPHIC CHANGES.
4 __SATIS FOR EVALUATION
5 __ENDCX/MET CELLS IDENT
6 __ENDCX/MET CELLS NOT IDENT
7 __UNSAT FOR EVALUATION (SEE COMMENT)

III. GENERAL CATEGORIZATION

8 __NEG FOR IL/MALIG
9 __EPITH CELL ABN (SEE INTERP/COMMENT)
10 __OTHER (SEE COMMENT)

IV. INTERPRETATION/DIAGNOSIS

SQUAMOUS ABNORMALITIES

11 __ASCUS, UNDET (SEE COMMENT)
12 __ASCUS CAN'T EXCLUDE HSIL (SEE COMMENT)
13 __LSIL
14 __HSIL

16 __SQUAMOUS CA

GLANDULAR ABNORMALITIES

17 __AGUS, PROB ENDCX ORIGIN (SEE COMMENT)
18 __AGUS, PROB ENDOMET ORIGIN (SEE COMMENT)
19 __AGUS, NOS (SEE COMMENT)
20 __ENDCX ADENOCA IN SITU (SEE COMMENT)
21 __ADENOCA (SEE COMMENT)
22 __OTHER MALIG NEOPLASM (SEE COMMENT)

REACTIVE/INFLAMMATORY

23 __REACT/REPAIR
24 __SQUA MET
25 __REACTIVE ECC
26 __MILD INFL
27 __MOD INFL
28 __MARKED INFL

INFECTIOUS

30 __TRICH
31 __CANDIDA
32 __BACT VAGINOSIS
33 __ACTINO
34 __HERPES

HORMONAL

35 __ESTROGEN EFFECT
36 __ATROPHY
41 __PARTIAL ATROPHY

HPV

__HPVneg
__HPVpos
__HPVG _____ neg _____ pos

38 __REVIEWED BY PATHOLOGIST

CYTOTECH: _____ DATE: _____

COMMENT: