

PLEASE PRINT

Patient Name (Last)		<input type="checkbox"/> Jr <input type="checkbox"/> Sr	First	MI	RACE
Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security No.	Birthdate / /	Phone Number () -	
Patient Address (Street or Box No.) <input type="checkbox"/> NEW			Account Number		
County	City	State	Zip Code		

All tests ordered are medically necessary for diagnosis and treatment of this patient.

PHYSICIAN SIGNATURE

DATE

PHONE #

COPIES TO:

ORDERING PHYSICIAN

Insurance 1	Insurance 2
Company:	Company:
Address:	Address:
Policy #:	Policy #:
Group #:	Group #:
Employer	Guarantor/ Relationship

PLEASE SEND COPY OF FRONT AND BACK OF INSURANCE CARD.

PHYSICIAN NOTICE

When ordering tests, the physician is required to make an independent medical necessity decision with regard to each test the laboratory will bill. The physician also understands he or she is required to (1) submit ICD-9 diagnosis supported in the patient's medical record as documentation of the medical necessity or (2) explain and have the patient sign an ABN.

GYN CYTOLOGY	Date of Smear:
<input type="checkbox"/> Conventional Pap Smear	LMP: No. of Slides:
<input type="checkbox"/> Liquid Based Reflex HPV (For Ascus)	Source: <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina Other:
<input type="checkbox"/> Liquid Based	Cervix Present: <input type="checkbox"/> N <input type="checkbox"/> Y
<input type="checkbox"/> HPV Only	Treatment: <input type="checkbox"/> N <input type="checkbox"/> Y Type:
Must check one of the following (Required)	Previous Cancer: <input type="checkbox"/> N <input type="checkbox"/> Y Type:
<input type="checkbox"/> Non-Medicare Patient ICD-9 Code:	
<input type="checkbox"/> Medicare Patient (Check one below)	
<input type="checkbox"/> Screening – Low Risk, Cervical (V76.2) every 2 years	
<input type="checkbox"/> Screening – Low Risk, Other sites (V76.49) every 2 years	
<input type="checkbox"/> Screening – High Risk, Medical history (V15.89) one per year	
<input type="checkbox"/> Diagnostic – History of abnormality or signs or symptoms	
Diagnosis (ICD-9) 1) _____ 2) _____ 3) _____	

HISTOLOGY/NON-GYN CYTOLOGY SPECIMENS

Clinical Signs, Symptoms or Complaints [Reason for Obtaining Specimen(s)]:
Enter text:
Or ICD-9 ↓

ICD-9	Organ/Site	FNA	biopsy	excision	check margins	shave	punch	curetting	core/tru-cut
1									
2									
3									
4									
5									
6									

For all inquiries about surgical reports, specimen handling issues or fax requests, please call 1-410-820-0019

Chesapeake Pathology Associates

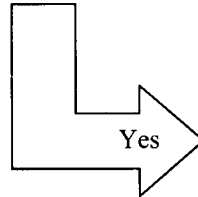
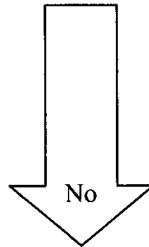
David B. Danner, M.D., Ph. D.
Medical Director
Reinhardt O. Sahmel, M.D., Ph. D.

INSTRUCTIONS FOR ORDERING A MEDICARE PAP TEST:

- A. FIRST, DECIDE WHETHER YOU WANT TO ORDER A CONVENTIONAL PAP OR THIN-PREP. CHECK THE APPROPRIATE BOX.
- B. SECOND, DETERMINE WHAT CATEGORY THE PATIENT FALLS INTO:

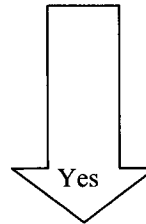
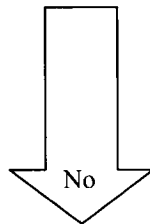
Does the patient have one or more of the following signs, symptoms, or complaints:

- a) previous cancer of the cervix, uterus, or vagina
- b) previous abnormal pap
- c) abnormal findings of the genital tract
- d) significant complaints relative to the genital tract
- e) signs or symptoms that may be reasonably associated with a gynecologic disorder



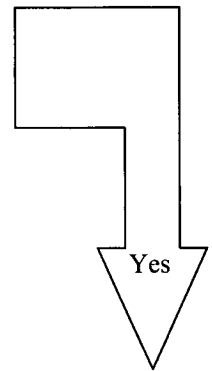
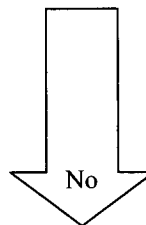
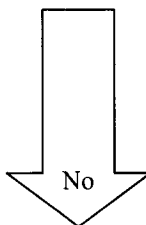
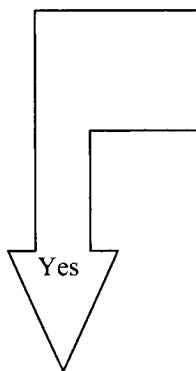
CHECK DIAGNOSTIC PAP BOX AND ENTER EITHER THE ICD-9 CODE (preferred) OR THE REASON FOR ORDERING THE PAP TEST

Does the patient have one or more of the following risk factors: **early onset of sexual activity, multiple sexual partners, history of STD, less than 3 paps within the prior seven years.**



Has the patient had a screening pap within the last 3 years?

Has the patient had a screening pap within the last year?



CHECK ROUTINE SCREENING PAP (Low Risk) BOX AND HAVE PATIENT SIGN ADVANCED BENEFICIARY NOTICE

CHECK ROUTINE SCREENING PAP (Low Risk) BOX

CHECK ROUTINE SCREENING PAP (Low Risk) BOX

CHECK ROUTINE SCREENING PAP (High Risk) BOX AND HAVE PATIENT SIGN ADVANCED BENEFICIARY NOTICE