PATHOLOGY SCIENCES MEDICAL GROUP
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PSMG

PATHOLOGY REQUEST

0000188
FEATHER RIVER HOSPITAL
5974 PENTZ ROAD
PARADISE, CA 95969
P: (530) 877-9361 F:(530) 876-7925

Procedure Date

Referring Physician

COPIES TO: _____
(Please include First and Last name and phone #)

PATIENT NAME			DATE
PREVIOUS NAME (If changed within last 5 years)			*DATE OF BIRTH*
MAILING ADDRESS			AGE / SEX M F
CITY	STATE	ZIP	PHONE
insurance info ❑ attached or completed below			
INSURANCE CO.			
INSURANCE ID #		GROUP #	
2ND INSURANCE, ID #, AND GROUP #			
S-CODE for FPACT Program (see back of form)			

GYN CYTOLOGY / MOLECULAR DIAGNOSTICS

See reverse for frequently used ICD-9 codes

Test (Required)	ICD-9 (Required)
❑ Pap Smear Reflex to HPV if: ❑ ASCUS	❑ V72.31 ❑ V76.2 ❑ V15.89 ❑ Other _____ ❑ Diagnostic _____
❑ HPV Screening	❑ V73.81 ❑ Other _____ Some Insurances may not cover HPV screening
❑ Gonorrhoeae/Chlamydia	❑ V74.5 ❑ V01.6 ❑ Other _____
❑ Herpes Simplex (I/II)	❑ V74.5 ❑ V01.6 ❑ Other _____
❑ Vaginitis Panel: Candida, Gardnerella, Trichomonas (BD AFFIRM VPIII Collection Kit only)	❑ 616.10 ❑ Other _____

SOURCE
- ❑ Cervix/EndoCx
- ❑ Vag only (hysterectomy)
- ❑ EndoCx Sleeve

LMP: _____

HORMONE STATUS
- ❑ OCP ❑ IUD
- ❑ Contraceptive (other) Ring, Patch, Depo Provera
- ❑ Pregnant, _____ wks
- ❑ Postpartum
- ❑ Postmenopausal
- ❑ Hormone replacement

GYN HISTORY
- ❑ Hysterectomy, total
- ❑ Hysterectomy, supracervical
- ❑ Abnormal bleeding
- ❑ Any GYN malignancy
- ❑ Chemotherapy/pelvic radiation
- ❑ H/O abnl pap, CIN, or HPV
- ❑ Other: _____

PREVIOUS PAP SMEAR
Date: _____
- ❑ Negative
- ❑ Unsatisfactory
- ❑ Abnormal: _____

Advanced Beneficiary Notice (ABN) for Medicare Patients only:
Medicare covers payment for routine gynecologic Pap Screening once every TWO years. Medicare generally does not cover screening for HPV, GC, Chlamydia, or vaginal inflammatory conditions. Therefore, payment may be denied. By my signature below, I elect to receive the service and agree to be personally and fully responsible for payment if Medicare coverage is denied.

SIGNATURE (required): _____

TISSUE SPECIMEN / NON-GYN CYTOLOGY

CLINICAL DATA

SPECIMEN TYPE & ANATOMIC SITE

❑ request AFB stain

❑ request fungal/pneumocystis stain

OFFICE USE: FS or RS:

Version 10/2012