bellinhealth
Outreach Laboratory

Account Name: _____

(Patient Sticker)

PAP REQUISITION

********<u>All</u> the information on this form must be provided – Any omissions will require a follow-up call to your facility before the specimen can be processed. ********

_____ PAP Smear, Imaged (88175.03)

_____ PAP Smear, Slide (P3000.04)

Reflex HPV Testing:

- ☐ Do Not Reflex
- ☐ Reflex only if ASCUS
- ☐ Reflex only if ASCUS or NEGATIVE

*** If HPV is requested REGARDLESS of PAP result, <u>order</u> HPV THINPREP (87621.11). ***
*** If Chlamydia/GC testing is requested, <u>order</u> Chlamydia/GC, Thin Prep PCR (LAB491). ***

Patient Name: _____ DOB: _____
Last First MI

Patient ID: _____ Physician: _____ SSN: _____

Collection Date: _____

Source:
- ____ Cervical
- ____ Cervical/Vaginal
- ____ Other
- ____ Vaginal

Screen ____vs. **Diagnostic** ____ (check one only)

Patient History and Treatments: (provide date)
- _____ Biopsy
- _____ Cold Knife Conization
- _____ Colposcopy
- _____ Colposcopy & Biopsy
- _____ Conization
- _____ Cryosurgery
- _____ D & C
- _____ Laser
- _____ LEEP
- _____ No previous history
- _____ Other Procedure (please note)
- _____ Previous Atypical
- _____ Previous Negative
- _____ Previous Unsatisfactory Specimen
- _____ Info not provided

Clinical Info:
- ____ Birth Control Meds
- ____ Bleeding
- ____ Depo-Provera
- ____ DES exposure
- ____ Hormonal Therapy
- ____ Hysterectomy
- ____ Intra-uterine device
- ____ Irregular Menses
- ____ No clinical info
- ____ Other (please note)
- ____ Post menopausal
- ____ Post Partum
- ____ Pregnant
- ____ Previous Abnormal
- ____ Radiation Therapy
- ____ Vaginal discharge
- ____ None provided

L.M.P.: _____

Notes: _____

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The following section must be completed for those patients whose test(s) will be billed to Medicare or Medical Assistance through Bellin Outreach Laboratory. Optional-attach face sheet including diagnosis coding. If information is incorrect or incomplete, services will be billed to the submitting facility.

Patient Address: _____ City/State/Zip: _____

Medicare Number: _____ Medicaid Number: _____

Diagnosis Codes (no narratives accepted):

Screening: ___ Z12.4 ___ Z91.89 ___ Z12.72 ___ Z12.89 ___ Z01.419 Other: _____

Diagnostic: _____

Please complete an "Advance Beneficiary Notice" if service is deemed noncovered (e.g., Screening PAP done in last two years).