

NEW Cytology Requisition Aide – 11.2021

Old Cytology Requisition

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Differences in Requisitions

1. Numbered stickers have been eliminated from the new Cytology requisition; if you use pre-printed labels you **MUST** include the specimen source or use fill in labels to identify **ALL** specimens.
2. Complete **ALL** patient related information or use pre-printed label. Include location and phone information on each requisition.
3. One requisition per patient
4. Include Clinical History
5. Specimen source MUST be documented on the requisition and specimen label (s)

BE SPECIFIC

Specimen Labels – for each specimen

- Use printed labels (Meditech Generated) - or
- Label on Container - or
- Blank Labels – included with requisitions

All Labels MUST Include:

- **Full Legal Name**
- **Date of Birth**
- **Specimen Source (be specific)**
- **Collection Date**



Name _____
 DOB _____
 Specimen _____
 Source _____
 Collection Date _____

PATHOLOGY DEPARTMENT			
310 Sunnyview Lane Kalispell, MT 59901 (406) 751-5762 (406) 758-7064 fax			
Place patient label stamp here:			
Last Name	First Name	MI	Birthdate
Street Address			Apt #
City		State	Zip
Telephone			Sex
			M F
GUARANTOR NAME		Relationship to Patient	
		Self Spouse Parent Other	
Street	City	State	Zip
Insurance Co.	Policy #	Group #	
Address			
Bill Physician Bill Patient Medicaid Medicare			Medicaid/Medicare #
NON-GYN CYTOLOGY			
SPECIMEN SOURCE:			
URINE CYTOLOGY <input type="checkbox"/> VOIDED <input type="checkbox"/> CATHETERIZED <input type="checkbox"/> BARBOTAGE			
PROCEDURE PERFORMED:			
CLINICAL INFORMATION:			
<p>When ordering tests for which Medicare reimbursement will be sought, physicians or provider shall only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. The provider's signature is required by CMS.</p> <p>Important Note: Please provide pertinent clinical history, clinical impression and physical findings (size, appearance, duration, location of a lesion), imaging and laboratory studies, etc., as they may affect the pathologic diagnosis in some situations.</p>			

<u>IMPORTANT NOTE:</u>	
<ul style="list-style-type: none"> • 1 Requisition Per Patient • Document Source required on the Specimen Label and the Requisition 	
Use For CYTOLOGY Orders ONLY	
Submitting Provider Signature	
Printed Name	
Copies to:	
Collection Date / Initials:	Accession Number
Date Received:	
GYN CYTOLOGY	
<input type="checkbox"/> Routine Screen <input type="checkbox"/> High Risk Patient Screen <input type="checkbox"/> Diagnostic *Please use Medicare guidelines ICD-9:	
AUTOCYTE PAP TEST	
<input type="checkbox"/> Pap Only <input type="checkbox"/> Pap with Reflex HPV for: <input type="checkbox"/> ASCUS, ASC-H <input type="checkbox"/> LGSIL <input type="checkbox"/> Reactive Changes	
<input type="checkbox"/> Pap and HPV Test (HPV performed irrespective of pap result) <input type="checkbox"/> HPV Test Only (no pap test will be performed)	
<input type="checkbox"/> GC/Chlamydia <input type="checkbox"/> GC only <input type="checkbox"/> Chlamydia only	
<input type="checkbox"/> GC/Chlamydia test only (no pap test will be performed)	
Specimen Source: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical	
<input type="checkbox"/> Other	
CLINICAL HISTORY:	
LMP (mm/dd/yyyy) _____ <input type="checkbox"/> IUD <input type="checkbox"/> BCP <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Pregnant _____ wks <input type="checkbox"/> Estrogen Therapy <input type="checkbox"/> Post-partum _____ wks <input type="checkbox"/> Post Menopausal <input type="checkbox"/> Breast feeding <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> TAH <input type="checkbox"/> BSO <input type="checkbox"/> Partial <input type="checkbox"/> No Previous Abnormal Cytology <input type="checkbox"/> Atypical squamous cells, undetermined significance <input type="checkbox"/> Atypical glandular cells, undetermined significance <input type="checkbox"/> Low grade squamous intraepithelial lesion <input type="checkbox"/> High grade squamous intraepithelial lesion Additional History:	