Office Name_____
Address_____
Phone Number_____
Fax Number_____

Ordering Provider_____
(Print First and Last Name)

DID YOU INCLUDE...
- **DIAGNOSIS CODE(S)?**
- **TEST(S) TO BE PERFORMED?**
- **PROVIDER FIRST/ LAST NAME?**
- **WHO TO BILL?**

CYTOLOGY OUTPATIENT REQUEST FORM

PROVIDENCE
Alaska
Medical Center
P.O. Box 196604 Anchorage, AK 99519-6604

CYTOLOGY (907) 212-3098
FAX (907) 212-4873

ORDERING PROVIDER SIGNATURE: _____

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED. USE BLACK OR BLUE INK ONLY

PATIENT'S FULL LEGAL NAME (REQUIRED) LAST:	FIRST:	MI:
DATE OF BIRTH (REQUIRED):	**SEX (REQUIRED):** ☐ MALE ☐ FEMALE	

☐ **STAT**
Phone: _____
Fax #: _____
☐ Fax Results Immediately

DIAGNOSIS ICD CODE(S) (REQUIRED):	ADDITIONAL COPIES TO:

BILL: ☐ **CLIENT/PHYSICIAN ACCOUNT #:_____ COMPLETE REQUIRED AREAS** ☐ **PATIENT BILL COMPLETE REQUIRED & AREAS BELOW** ☐ **INSURANCE COMPLETE ALL AREAS**	SUBSCRIBER (LAST, FIRST, MIDDLE)	DATE OF BIRTH

GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FOR MEDICARE)	DATE OF BIRTH	ADDRESS (CITY, STATE, ZIP)

ADDRESS	PHONE #	PATIENT RELATIONSHIP
CITY/STATE/ZIP CODE:	INSURANCE CO.	
PT. RELATIONSHIP:	CLAIMS ADDRESS (CITY, STATE, ZIP)	

HOME PHONE NO.:	WORK PHONE NO.:	INSURANCE PHONE	INSURANCE/MEMBER POLICY #	GROUP #

TODAY'S DATE (REQUIRED):	**COLLECTION DATE (REQUIRED):**	**COLLECTION TIME (REQUIRED):**

GYNECOLOGIC CYTOLOGY

SOURCE:
- ☐ CERVICAL
- ☐ VAGINAL
- ☐ ENDOCERVICAL

HPV testing includes screening for Genotype 16, 18 & 12 other High Risk variants.
- ☐ PAPLQ (LAB12010) - Pap Only (Liquid)
- ☐ PAPHP (LAB13425) - Pap+HPV (regardless)
- ☐ PAPACR (LAB23708) - Pap+Reflex to HPV if ASCUS
- ☐ PSHPV (LAB2138) Misc. HPV Primary Screen reflex enter test comment PAML test code PSHPV
- ☐ SLIDES _____ (Please indicate # of slides)
- ☐ GC/CHL by PCR (LAB1376) - Using Liquid Based Pap

One of the Following Must Be Checked (Required)
- ☐ Screening PAP
- ☐ Screening High Risk PAP
- ☐ Diagnostic PAP

(FOR MEDICARE SEE NOTICE ON REVERSE)

GYN HISTORY

LMP MM/DD/YY _____ (REQUIRED)

☐ Routine Exam	☐ Estrogen Therapy	☐ DES Exposure
☐ Oral Contraceptives	☐ Abnormal Bleeding	☐ Radiation
☐ Pregnant _____ wks	☐ IUD	☐ Chemotherapy
☐ Post Partum ____ wks	☐ History of Malignancy	☐ Gyn Biopsy
☐ Post Abortion	☐ Hysterectomy (total)	☐ Gyn Cone
☐ Post Menopausal	☐ Hysterectomy (cervix intact)	☐ Gyn Surgery

ABNORMAL PAP HISTORY: *(INCLUDE DATES)*

_____

NON-GYNECOLOGIC CYTOLOGY

- ☐ SPUTUM
- ☐ BRONCH. WASH: Lobe _____ ☐ LEFT ☐ RIGHT
- ☐ BRONCH. BRUSH: Lobe _____ ☐ LEFT ☐ RIGHT
- ☐ BAL Indicate Lobe _____
- ☐ PLEURAL (CHEST) FLUID ☐ LEFT ☐ RIGHT
- ☐ ASCITES (ABDOMINAL) FLUID
- ☐ URINE *(FRESH ONLY)*
- ☐ BREAST NIPPLE SECRETION ☐ LEFT ☐ RIGHT
- ☐ CSF
- ☐ OTHER _____
- ☐ BRUSHINGS SOURCE _____

FINE NEEDLE ASPIRATION
- ☐ BREAST ☐ LEFT ☐ RIGHT
- ☐ THYROID ☐ LEFT ☐ RIGHT
- ☐ LYMPH NODE SITE _____
- ☐ OTHER _____

MISCELLANEOUS

- ☐ PNEUMOCYSTIS STAIN (MICROBIOLOGY)
- ☐ URINE HEMOSIDERIN
- ☐ RECURRENT ASPIRATION PANEL (LIPID)
- ☐ TZANCK SMEAR
- ☐ OTHER _____

CLINICAL HISTORY

LAB USE ONLY:

ACCESSION NUMBER: _____
MEDICAL RECORD #: _____
ACCOUNT NUMBER: _____