LABORATORY REQUEST TISSUE

CLIENT I.D. #
( )

PLACE COMPUTER LABEL HERE (FOR LBM USE ONLY)

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED OR CLIENT ACCOUNT WILL BE BILLED.

PATIENT'S NAME LAST	FIRST	M.I.	SEX ( ) M ( ) F	**D.O.B. (REQUIRED)**	TELEPHONE #

PATIENT'S ADDRESS	CITY / STATE / ZIP CODE	**PATIENT'S SS# / ID#**	**PATIENT SIGNATURE - Release of records & direct payment to lab**

ORDERING PHYSICIAN SIGNATURE**	**PRINT NAME**	**COPY TO:**	**DATE COLLECTED**	**TIME COLLECTED**	TECH

☐ **STAT - CALL ______ OR FAX ______** ☐ **DURING OFFICE HOURS ONLY TO:** ☐ **PHONE #** ______ ☐ **FAX #** ______

COMPLETE FOR ALL BILLING TYPES (Please attach a copy of MEDI-CARE or Insurance Card) **REFLEX TESTS RESULT IN ADDITIONAL CHARGES**

BILL TO: ☐ PATIENT ☐ INSURANCE ☐ IPA/HMO CAPITATION ☐ MEDICARE **(ABN/MSPQ?)** ☐ MEDI-CAL ☐ CLIENT/PHYSICIAN

RESPONSIBLE PARTY/POLICY HOLDER	RELATIONSHIP TO PATIENT ____ SELF ____ SPOUSE ____ OTHER	SOCIAL SECURITY #	EMPLOYER

INSURANCE COMPANY / IPA PLAN	AUTHORIZATION #	ID OR POLICY NO.	MEDICAL / MEDICARE NO.

INSURANCE COMPANY ADDRESS	CITY / STATE / ZIP CODE

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DX ______

Tech ID ______

CYTOLOGY REQUEST

AGE AND CLINICAL HISTORY REQUIRED BY STATE AND FEDERAL REGULATIONS

TEST

- ☐ ThinPrep® ONLY
- ☐ ThinPrep® REFLEX HPV IF ASCUS ($\geq$ 21 YEARS OLD ONLY)
- ☐ ThinPrep® AND HPV CO TEST ($\geq$ 30 YEARS OLD ONLY)
- ☐ SurePath ONLY
- ☐ SurePath REFLEX HPV IF ASCUS ($\geq$ 21 YEARS OLD ONLY)
- ☐ SurePath AND HPV CO TEST ($\geq$ 30 YEARS OLD ONLY)
- ☐ PAP SMEAR (Conventional)

ANCILLARY TEST

(On ThinPrep® vial or SurePath vial)

- ☐ CHLAMYDIA / GC
- ☐ CHLAMYDIA
- ☐ GC

SITE

- ☐ CERVICAL - ENDOCERVICAL
- ☐ CERVICAL
- ☐ VAGINAL
- ☐ VAGINAL CUFF (HYST.)

CLINICAL HISTORY

- ☐ ABNORMAL BLEEDING
- ☐ PREGNANT
- ☐ POST PARTUM
- ☐ POST MENOPAUSAL
- ☐ HYSTERECTOMY - TOTAL
- ☐ HYSTERECTOMY - CX REMAINS
- ☐ HORMONE THERAPY TYPE ______
- ☐ IUD
- ☐ PREVIOUS CANCER SITE ______
- ☐ IRRADIATION DATE ______

DATE OF LMP: ______

- ☐ REGULAR
- ☐ IRREGULAR
- ☐ PREVIOUS / CONCURRENT CERVICAL BIOPSY: #______ DATE______
- ☐ REPEAT OF ATYPICAL PAP: GY / GT / GS______ DATE______

LABEL SLIDES IN PENCIL WITH PATIENT'S LAST NAME

- ☐ OUTSIDE ATYPICAL PAP SHOWING: ______

	NON-GYN CYTOLOGY	
	HERPES TZANCK PREP. SOURCE:	
	SPINAL FLUID FOR TUMOR CELLS	(SF)
	SPUTUM	(SP)
	URINE, CATH	(URCZ)
	URINE, VOIDED	(UVOID)
	BONE MARROW	
	BONE MARROW EVALUATION	
	FLOW CYTOMETRY	
	CHRONIC LYMPHOPROLIFERATIVE DISORDER	
	ACUTE LEUKEMIA PANEL	
	CYTOGENETICS	
	FISH - PLEASE SPECIFY ______	
	OTHER	

DO NOT COMBINE TISSUE AND CYTOLOGY IN ONE ORDER (USE SEPARATE REQUISITION)

TISSUE REQUEST

CLINICAL INFORMATION OR INSTRUCTION

______

ICD-9 / ICD-10 (October 2015) ______

TISSUE SUBMITTED:

______

FOR LABORATORY USE ONLY

TISSUE NUMBER

ADVANCE BENEFICIARY NOTICE

Medicare will only pay for services that it determines to be medically reasonable and necessary under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular test, although it would otherwise be covered, "is not reasonable and necessary", under the Medicare Program Standards, Medicare will deny payment.

By signing the separate acknowledgement form you are agreeing to be financially responsible for payment.

LABORATORY SITE

A. LBM PATHOLOGY MEDICAL GROUP • 2801 ATLANTIC AVENUE, LONG BEACH, CA 90806 (562) 933-0777

M. HOSHIKO, M.D., DIRECTOR