



LABORATORY MEDICINE CONSULTANTS

GYNECOLOGIC CYTOLOGY REQUISITION

SPECIMEN NUMBER

REFERRING PHYSICIAN

SPECIMEN DATE	CLIENT INFORMATION NUMBER
PATIENT NAME (LAST, FIRST, MI)	
PATIENT ADDRESS	
PATIENT (CITY, STATE, ZIP)	
PATIENT SOCIAL SECURITY NUMBER	PATIENT DATE OF BIRTH
PATIENT PHONE NUMBER (AREA CODE, NUMBER)	PATIENT AGE PATIENT GENDER

ADDITIONAL COPY OF RESULTS TO: (Last Name) (First Name) (Fax Number)

B PLEASE ATTACH A COPY OF THE PATIENT'S DRIVERS LICENSE FRONT AND BACK AND A COPY OF THE PATIENT'S INSURANCE CARD FRONT AND BACK

Financial and release of information authorization: In consideration for services rendered, I/we hereby assign the benefits due me covering the services provided by Laboratory Medicine Consultants, including major medical benefits. I/we authorize the release of information necessary for insurance purposes, further, that in consideration of service rendered to the patient, I/we hereby obligate myself/ourselves to assume responsibility for full payment of account.

NAME OF INSURED (SUBSCRIBER)	LAST	FIRST
PATIENT IS:	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE
	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER
INSURED EMPLOYER AND ADDRESS:	CITY	STATE/ZIP
PRIMARY INSURANCE	MEDICARE/MEDICAID NUMBER	GROUP NAME/NUMBER
SECONDARY INSURANCE		GROUP NAME/NUMBER
INSURED OR PATIENT SIGNATURE FOR FINANCIAL AND RELEASE OF INFORMATION	DATE	

PLEASE BILL: (CHECK BOX)

DOCTOR/CLIENT PATIENT INSURANCE (BELOW)

DIAGNOSIS (SPECIFY ICD 9 CODES) HIGHEST SPECIFICITY REQUIRED

1. | 2.

3. | 4.

IMPORTANT PLEASE INDICATE IF THIS SPECIMEN IS FOR : SCREENING DIAGNOSTIC HIGH RISK **IMPORTANT**

SEE BACK OF REQUISITION SLIP FOR ADDITIONAL INFORMATION

CLINICAL INFORMATION - CHECK ALL THAT APPLY

TESTS	CONDITION	HISTORY
<input type="checkbox"/> THINPREP® PAP TEST Submitted in Thinprep vial <input type="checkbox"/> Reflex to HPV Testing: <input type="checkbox"/> if ASC - US <input type="checkbox"/> if AGUS <input type="checkbox"/> High Risk HPV Testing-Digene <input type="checkbox"/> High Risk HPV Testing-PCR <input type="checkbox"/> Other: _____ <input type="checkbox"/> Conventional PAP Smear (Submitted on Glass Slide) SPECIMEN SOURCE <input type="checkbox"/> CERVICAL / ENDOCERVICAL <input type="checkbox"/> VAGINAL <input type="checkbox"/> VULVAR LESION <input type="checkbox"/> OTHER _____ TODAY'S EXAM <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> BIOPSY TAKEN	LMP DATE: _____ <input type="checkbox"/> HYSTERECTOMY, TOTAL <input type="checkbox"/> PARTIAL HYSTERECTOMY (CERVIX REMAINS) <input type="checkbox"/> PREGNANT <input type="checkbox"/> POST PARTUM (0-6 WK.) <input type="checkbox"/> PERI-MENOPAUSAL <input type="checkbox"/> POST MENOPAUSAL <input type="checkbox"/> BREAST FEEDING <input type="checkbox"/> ABNORMAL / IRREGULAR BLEEDING <input type="checkbox"/> AMENORRHEA <input type="checkbox"/> DISCHARGE PRESENT <input type="checkbox"/> IUD <input type="checkbox"/> IRRITATION/INFLAMMATION <input type="checkbox"/> HERPES HORMONAL THERAPY <input type="checkbox"/> ORAL CONTRACEPTIVES <input type="checkbox"/> HORMONE THERAPY <input type="checkbox"/> OTHER: _____	LAST PAP DATE: _____ <input type="checkbox"/> LMC <input type="checkbox"/> OTHER LAB _____ <input type="checkbox"/> DIAGNOSIS: _____ <input type="checkbox"/> PRIOR ABNORMAL PAP <input type="checkbox"/> PREVIOUS DYSPLASIA <input type="checkbox"/> CRYOSURGERY <input type="checkbox"/> LEEP <input type="checkbox"/> PREVIOUS CERVICAL CONIZATION <input type="checkbox"/> PREVIOUS MALIGNANCY <input type="checkbox"/> CHEMOTHERAPY <input type="checkbox"/> PREVIOUS RADIATION THERAPY CERVICAL CANCER RISK FACTORS <input type="checkbox"/> HPV <input type="checkbox"/> SMOKER <input type="checkbox"/> DES EXPOSURE <input type="checkbox"/> HIV

ADDITIONAL INFORMATION:

ADVANCE BENEFICIARY NOTICE:

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Specifically, Medicare will deny payment for a Screening Pap Smear if you have had one during the last two years.

MEDICARE BENEFICIARY AGREEMENT

NOTE: To be signed by Medicare Beneficiaries ONLY.

PLEASE CHECK ONE OF THE BOXES I believe that I have not had have had a screening pap smear in last two years.

"I have been notified by my physician or laboratory that Medicare may deny payment for a Screening Pap Smear. If Medicare denies payment for this pap smear, I agree to be personally and fully responsible for payment."

BENEFICIARY SIGNATURE: _____ DATE: _____

LMC COPY

SCREENING VS DIAGNOSTIC PAP SMEARS

Screening Pap = A pap that is ordered in the absence of signs or symptoms of a disease.

1. **Diagnosis code V76.2 for low risk patients**
2. **Diagnosis code V15.89 for high risk patients (See criteria)**

Diagnostic Pap = A pap ordered due to signs or symptoms present.

(Use appropriate diagnosis code for condition)

CRITERIA FOR HIGH RISK CERVICAL OR VAGINAL CANCER

1. **Previous gynecological history of dysplasia.**
2. **Personal history of cancer.**
3. **Sexual experience before 16 years of age.**
4. **Five or more sexual partners in lifetime.**
5. **Fewer than 3 negative pap smears within the previous 7 years.**
6. **DES exposure in utero.**
9. **History of STD (Including HIV infection).**

INSTRUCTIONS FOR OBTAINING AND SENDING SPECIMENS FOR CYTOLOGIC EXAMINATION

- ❖ **ThinPrep® Pap Preparation:** (1) Print patient's name on specimen vial and fill out requisition. (2) Follow directions for obtaining specimen provided by LMC. **DO NOT USE A WOODEN SCRAPER: USE ONLY PLASTIC SCRAPER, BRUSH OR BROOM PROVIDED BY LMC.** (3) After collection, aggressively agitate the collection device into the vial. (4) Discard collection device and securely recap the vial. (5) Place the labeled vial and completed requisition slip into a transport bag for courier pickup.
- ❖ **Conventional Pap Smear:** (1) Print patient's name with pencil on frosted end of slide and fill out requisition before obtaining smear. (2) Do not use lubricant on speculum. (3) To obtain a specimen from the cervical transformation zone, it is suggested a cervical broom or cervical spatula with endocervical brush be used. Follow standard collection techniques as recommended by the manufacturer. Rotate and draw brush across slide to deposit material. **SPRAY WITH FIXATIVE IMMEDIATELY.** (The endocervical brush is not for use on pregnant patients or inflamed tissue. The endocervical brush is not for sampling the endometrium). (4) Label slides to indicate from which area the specimen is taken (C for cervical, V for vaginal). (5) As each slide is taken, fix it immediately with commercially available spray fixatives. Hold the spray 10-12 inches from the slide(s) to avoid freezing artifact. Spray for 10-15 seconds. Allow spray to dry on the slides. (6) Place slides in slide container for transporting.