SPECIMEN COLLECTION: DATE: TIME:	HIS LABEL	LIS LABEL

ALBANY MEDICAL CENTER
DIVISION OF ANATOMIC PATHOLOGY CYTOPATHOLOGY
43 New Scotland Avenue
Albany, New York 12208

PH: (518) 262-5454
FAX: (518) 262-3663

NAME: DOB: SEX:

MAIDEN / PRIOR NAMES:

ADDRESS:

CITY: STATE: ZIP:

GUARANTOR:

INSURANCE CO.: PLAN NAME:

SUBSCRIBER: RELATIONSHIP TO SUBSCRIBER:

ID# GROUP #:

SECONDARY INSURANCE CO.: PLAN NAME:

SUBSCRIBER: SUB DOB: RELATIONSHIP TO SUBSCRIBER:

ID# GROUP #:

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:

MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

ICD 10 CODES / DIAGNOSIS:

GYN CYTOLOGY TESTING

Test(s): ☐ Conventional Pap ☐ Thin Prep Pap (TP) ☐ Image Guided TP Pap

Source: ☐ Vaginal ☐ Cervical/Endocervical

Microbiology: * ☐ GC and CHLAMYDIA ☐ GC only ☐ CHLAMYDIA only

HPV Testing (orderable on TP PAP only): ☐ Trichomonas

☐ HPV testing regardless of PAP diagnosis ☐ Add HPV 16 & 18/45 Genotyping if HPV positive

☐ HPV testing if ASCUS

☐ HPV testing if ASCUS or SIL

Diagnosis/History: (must be completed)

Screening PAP (Patient has no present signs or symptoms of GYN disease)

☐ Low risk patient ☐ High risk patient ☐ DES Exposure

Diagnostic PAP (Patient has abnormal history or present GYN symptoms) *(complete below)*

☐ Previous GYN Malignancy ☐ Suspicious Lesion ☐ Inflammation of GYN tract

☐ Abnormal Pap ___/___/____ ☐ Pelvic Mass ☐ Radiation ___/___/____

☐ Abnormal Biopsy ___/___/____ ☐ Abnormal Bleeding ☐ Chemotherapy ___/___/____

Patient Information: (must be completed)

Date of LMP:___/___/____ Last Pap Smear: Date:___/___/____ Results:_____

☐ Post menopausal ☐ Birth Control Pills ☐ Hormone Replacement

☐ Pregnant # of weeks_____ ☐ Post partum Delivery date:___/___/____

Surgical Procedure: Date:___/___/____ Results:_____

Hysterectomy: ☐ Total ☐ Supracervical

NON-GYN CYTOLOGY TESTING

Test Requested: ☐ Right ☐ Left

☐ Respiratory	☐ Urine, Collect method:	☐ CSF		
☐ Sputum	☐ Bladder Wash	☐ FNA:	Site:	
☐ Bronchial Wash/Lavage	☐ Catheterized	☐ Fluid:	Site:	
☐ Bronchial Brushing	☐ Voided	☐ Other:	Specify:	
	☐ Other:	☐ Special Request:	Specify:	

SURGICAL PATHOLOGY TISSUE ANALYSIS

Note specimen letter and write a source description for each one.

Record the letter and source description on the specimen container.

Container Letter **Source Description**

A.

B.

C.

D.

E.

F.

CLINICAL HISTORY

PRE-OP DIAGNOSIS

SURGICAL PROCEDURE

Additional comments

☐ Infectious Material Please Specify:

Surgical Procedure Requested:

☐ Routine Histology ☐ Immunofluorescent Studies

☐ Electron Microscopy ☐ Other Studies (specify):

Ordering practitioner: _____ MD / NP / PA circle one
print first and last name

Ordering practitioner: _____ MD / NP / PA circle one
signature

Ordering practition contact #:

If ordering is PA, NP or Resident
Supervising MD is REQUIRED: _____
print first and last name

Proceduralist (print)

Proceduralist (signature)

Copy To: _____
Please print first and last names

Copy To (Phone #):

Copy to (Fax #):

Copy To (Address):