THE SARATOGA HOSPITAL

PATHOLOGY OFFICE: (518) 583-8442
FAX: (518) 580-2661

OUTPATIENT PATHOLOGY / CYTOLOGY REQUISITION

ACCT. NO. LAB NO.

Patient Last Name	**First Name**	**MI**	**Date of Birth**	Sex	Marital Status	Social Sec #
Patient Street Address		City		State	Zip Code	Home Phone
Guarantor Last Name	First Name	MI	Date of Birth		Relationship	Social Sec #
Primary Ins Name	Patient Policy #	Grp #	Subscriber/Member Name		Subscriber/Member #	Subscriber/Member DOB
Secondary Ins	Patient Policy #	Grp #	Subscriber/Member Name		Subscriber/Member #	Subscriber/Member DOB

REQUESTING PHYSICIAN SIGNATURE:	**Requesting Physician Name (PRINT:)**	**DATE**	COPY TO:

FOR MEDICARE AND OTHER INSURED PATIENTS, I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS OR ANY OTHER GOVERNMENT AGENCY OR INSURANCE CARRIER RESPONSIBLE FOR PAYMENT ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICARE OR OTHER CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT ABOVE.

PATIENT'S SIGNATURE:

PATHOLOGY

SPECIMEN:

CLINICAL DIAGNOSIS

ICD-9 CODES _____

CYTOLOGY NON-GYN

☐ SPUTUM
☐ URINE: ☐ VOIDED ☐ CATHETER
☐ BODY FLUID (SOURCE): _____
☐ ASPIRATION (SOURCE): _____
☐ OTHER (SOURCE): _____
PREVIOUS HISTORY: _____

CLINICAL DIAGNOSIS

ICD-9 CODES _____

CYTOLOGY GYN

☐ SCREENING PAP
☐ DIAGNOSTIC PAP
☐ HPV if ASCUS

CLINICAL DIAGNOSIS

ICD-9 CODES _____

☐ CERVICAL ☐ PRENATAL ☐ DISCHARGE ☐ IUD LMP: _____
☐ VAGINAL ☐ POSTPARTUM ☐ ABNORMAL ☐ HORMONE RX DATE OF LAST PAP: _____
☐ ENDOCERVICAL ☐ POSTMENOPAUSE BLEEDING ☐ ONE SLIDE ☐ TWO SLIDES
☐ THIN PREP

PREVIOUS HISTORY/ABNORMAL CYTOLOGY/TREATMENT:

OTHER TESTS: