HEALTHLAB

Midwest Pathology Services
Dept. 4003
Carol Stream, IL 60122-4003
630-933-6636

Cytology/ Surgical Pathology Requisition

COPY TO (NAME):
FAX NUMBER:

***Physician Signature: _____

Ordering Physician(s)

0

Patient Information: (Please Print)

Bill To: ☐ My Account ☐ Medicare ☐ Other Insurance ☐ Patient ☐ Medicaid

Last Name | First | M.I.

Sex | Date of Birth | Social Security Number

Phone number | Patient Address

City | State | Zip Code

Date Collected | Time Collected : am pm | Collected by

Patient's Relationship to Insured: ☐ self ☐ spouse ☐ dependent

Responsible Party (omit if same):

Address:

City: | State: | Zip:

Payment by Medicare (Attach copy of Card- front & back)

Medicare Number | Suffix

Marital Status:

Payment by IDPA (Attach copy of Card- front & back)

Recipient #: | Case #:

Payment by Insurance (Attach copy of Card- front & back)

Insurance Name:

Insurance Address:

Policy #: | Group #:

Diagnosis related to ordered tests (ICD-10 codes effective 10-1-2015)

(1) | (3) | (5)

(2) | (4) | (6)

CYTOLOGY SECTION

PATIENT CLINICAL INFORMATION

Menstrual Status: ☐ Postmenopausal ☐ Pregnant ☐ Postpartum ☐ Hysterectomy

LMP Date: __/__/____

Hormones (Please Circle) HRT BCP IUD

Risk Factors : ☐ Yes ☐ No

Prev. Abnormal Pap(s), Result & Date: _____

Prev. CX BX, LEEP, Cone BX: _____

Significant Clinical Findings: _____

CYOLOGY TESTING

Gyne Source:
- ☐ Cervical
- ☐ Endocervical
- ☐ Cervical/Endocervical
- ☐ Vaginal

Pap Options:
- ☐ Conventional Pap
- ☐ ThinPrep Pap with Imager
- ☐ ThinPrep Pap w/o Imager

HPV Options:
- ☐ Reflex if Neg, Ascus or LSIL
- ☐ Reflex if Ascus or Above
- ☐ Reflex if Negative only
- ☐ Reflex if Neg or Ascus only
- ☐ Regardless of Result
- ☐ Reflex if no EC present only

Additional Testing:
- ☐ GC/Chlamydia
- ☐ Other_____

HPV 16/18 Options:
- ☐ If Pap Negative only
- ☐ If Pap Ascus only
- ☐ Regardless of Pap diagnosis

Non Gyne Source:
- ☐ **FNA**
  - Specify Site: _____
  - Clincial Data: _____
- ☐ **Body Fluid**
  - Specify Type & Site: _____
  - Clinical Data: _____

ACC#

SURGICAL PATHOLOGY SECTION

Clinical Diagnosis-History and Procedure: _____

Specimen(s) Submitted:

☐ Saline 1) _____

☐ Formalin 2) _____

☐ None 3) _____

4) _____

Req. Prepared By:

Surgery use only

FS ☐ Yes ☐ No ☐ Gross Imp. Only

Call Back Ext

CYTOLOGY LAB USE ONLY

Result

Negative EPCA UNSAT

HISTOPATH LAB USE ONLY

Codes _____ _____ _____ _____

Ordered By _____ Charged By _____ Gross Path _____

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