1-173783

HCRF-B

PROFESSIONAL SOLUTIONS USA, INC. • (336) 570-3813

DATE SUBMITTED / / | **REQUESTING PHYSICIAN** LAST / FIRST :

COPIES TO: (include initials) | LAST / FIRST : | FAX NUMBER

PATIENT INFORMATION: Please Print

PATIENT NAME: LAST | FIRST | MIDDLE

PATIENT MAILING ADDRESS

CITY | STATE | ZIP

TELEPHONE NO. | DATE OF BIRTH / / | SEX | RACE | S.S. NO.

PARENT NAME IF PATIENT UNDER 18 | CHART NO.

INSURANCE - COMPLETE OR ATTACH COPIES OF CARD(S)

	PRIMARY	SECONDARY
MEDICARE		
MEDICAID NC/VA/WVA		
BCBS•NC		
BLUE MEDICARE		
CIGNA		
MEDCOST		
UNITED		
SELF PAY		
OTHER		
OTHER		
OTHER		

PRIMARY

SUBSCRIBER NAME:

SUBSCRIBER ID:

GROUP #

INSURANCE CO. ADDRESS:

SUBSCRIBER'S EMPLOYER:

SECONDARY

SUBSCRIBER NAME:

SUBSCRIBER ID:

GROUP #

INSURANCE CO. ADDRESS:

SUBSCRIBER'S EMPLOYER:

CLINICAL HISTORY / EXAM / DIAGNOSIS / ICD CODE

PREVIOUS PATHOLOGY? #

WRITE COMPLETE NAME ON LABEL AND PLACE ON SPECIMEN.

SITE / ADDITIONAL CLINICAL Circle relevant items, add any other information

1

HISTOLOGY- BIOPSY EXCISION

CYTOLOGY- FNA URINE Voided Catheter PI. Effusion Left Right CSF

2

HISTOLOGY- BIOPSY EXCISION

CYTOLOGY- FNA URINE Voided Catheter RESPIR Wash Brush CSF

3

HISTOLOGY- BIOPSY EXCISION

FLOW CYTOMETRY- FNA of _____ BIOPSY of (site) MARROW Aspirate Core BLOOD OTHER

4

PAP SMEAR

Source: ☐ Cervix/Endocx or ☐ Vagina

Select ONE from the following:

☐ Non-Medicare Routine Screening Pap

☐ Diagnostic Pap

(Reason) _____

☐ Medicare Screening Pap

If so, ☐ Low risk ***or*** ☐ High risk

Required Clinical Information:

LMP: _____ ***or*** ☐ **Postmenopausal**

☐ Previous abnormal Pap _____

☐ Previous abnormal biopsy _____

☐ Pregnant ☐ Discharge

☐ Postpartum ☐ Abnormal exam

☐ Radiation/Chemo ☐ Immunosuppressed

☐ Hysterectomy ☐ Abnormal bleeding

☐ Contraceptive/hormone maintenance

Ancillary Testing:

☐ HPV test HIGH risk ONLY (if ASCUS)

☐ HPV test Regardless

☐ Chlamydia/Gonorrhea

For more specimens on this patient, staple additional HISTOLOGY / CYTOLOGY form to this one, complete name & birthdate sections

Check if URGENT ☐

If Urgent phone / page to _____

PATHOLOGY USE ONLY

		Cytopathology	*Molecular - Flow & morphometry*	
88302				
88304		88112	**-TC** 88184	(up to 1)
88305		88104	& 88185	(rest)
88307		88141	**-PC** 88187	(x1 for 2-8)
Decal and Stains		10021	or 88188	(x1 for 9-15)
88311		88172	or 88189	(x1 for 16+)
88312		88173	88360	(manual)
88313		**Frozen sections**	88361	(C-vis)
88342		88331	**Outside**	
		88332	88321	
			88323	

Front Copy to Pathology Back Copy for Patient's Chart

PATHOLOGISTS DIAGNOSTIC LABORATORY, PA
630 Brookwood Business Park Dr.
Winston Salem, NC 27105
www.pdspath.com

HISTOLOGY / CYTOLOGY REQUEST FORM

(336) 306-5777
Fax (336) 602-2609

Client Location & Phone Number

Lab accessn by

_____ - _____