Knowledge from people who care

Sabaneta Industrial Park A-234 Ponce, P.R. 00716
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www.southernpathology.com GYNS-04/2015

NEXT VISIT TO PHYSICIAN: / / (mm/dd/yy) LAB. NUMBER:

CYTOLOGY & SURGICAL PATHOLOGY REQUEST FORM

PATIENT INFORMATION

Patient Name: ____________ Age: ______ Gender: ◯F ◯M DOB: __/__/__ (mm/dd/yy)

SS No.: XXX-XX-______ Postal Address: ____________

Phone No: (   )   -   Medical Record No.: ____________

BILLING INFORMATION (Please provide copy of insurance card)

Bill to: ◯ Client ◯ Insurance ◯ Patient ICD 9/10 CODE: ____________

Health Insurance: ________ Insurance Contract No.: ________ Group No.: ________

GYNECOLOGICAL TESTING

Collection Date: __/__/__ (mm/dd/yy) Time: __:__ AM PM

Specimen Type: ◯Urine ◯Cervical ◯Vaginal

- ◯ Pap smear *(Conventional cytology)*
- ◯ ThinPrep *(Liquid based cytology)*
- ◯ Full panel *(ThinPrep, HPV reflex to 16/18, CT, NG)*
- ◯ HPV High Risk only
- ◯ HPV reflex to 16/18
- ◯ Chlamydia and Gonorrhea
- ◯ Chlamydia only
- ◯ Gonorrhea only
- ◯ GBS
- ◯ Herpes simplex
- ◯ Fetal Fibronectin
- ◯ Vaginal Culture
- ◯ Other: ________

URINE SPECIMENS (Non Gynecological)

- ◯ Gonorrhea only
- ◯ Chlamydia only
- ◯ Chlamydia and Gonorrhea
- ◯ Cytology
- ◯ UroVysion FISH
- ◯ Other: ________

NON GYNECOLOGICAL TESTING

Collection Date: __/__/__ (mm/dd/yy) Time: __:__ AM PM

Specimen Type: ◯Anal ◯Oral ◯FNA ◯Breast Smear RT / LT

◯Other: ____________

- ◯ Cytology
- ◯ HPV reflex to 16/18
- ◯ RPR (Syphilis)
- ◯ HPV High Risk only
- ◯ Other: ________

BIOPSY

- ◯ Cervical
- ◯ Endocervical
- ◯ Anal
- ◯ Endometrial
- ◯ Vaginal
- ◯ Oral

Other: ____________

Pre-OP Dx: ____________

Post-OP Dx: ____________

Clinical History: ____________

ORDERING PHYSICIAN

Physician Name: ____________

Address: ____________

Phone No: ____________

Physician Signature: ____________

CLINICAL INFORMATION

LMP: __/__/__ (mm/dd/yy) GRAVA ____ PARA ____ AB ____

Previous cytology: __/__/__ (mm/dd/yy) Dx: ____________

CHECK ALL THAT APPLY

- ◯ Hysterectomy — Date: __/__/__ (mm/dd/yy)
- ◯ Pregnant — Weeks: ______
- ◯ Abnormal Bleeding
- ◯ Vaginal Discharge
- ◯ Cryo of Cervix
- ◯ X ray Treatment
- ◯ Endocrine Therapy

Other: ____________

Yo autorizo a mi médico a proveer información a Southern Pathology Services para propósitos de facturación a mi Plan Médico. De mi plan médico no cubrir la(s) prueba(s) de patología, me hago responsable del costo ya sea del deducible o el costo total de la(s) prueba(s).

I authorize my physician to provide information to Southern Pathology Services for billing my medical insurance plan. I will be responsible for the deductible or total cost of test(s) if my medical insurance determines it is a non-covered service.

Patient Signature: ____________ **Date: (mm/dd/yy)** ________

This SLIP REQUEST is confidential and contains privileged information. Inappropriate disclosure is prohibited by law. If by accident you receive this request, please contact us immediately at 787-841-8645