107419

Pacific Rim PATHOLOGY

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PHYSICIAN:	cc: PHYSICIAN

Patient's Last Name	First	M.I.	SSN

Sex: M F	DOB	Age	Date Collected	MRN	Relationship to Insured/Responsible Party: ___Self ___Spouse ___Dependent

Address of Patient (or of Insured/Responsible Party if not the Patient)	Patient Phone #

City	State	Zip	Name of Insured/Responsible Party if not the Patient

Insurance Category:
- ☐ Medicare
- ☐ Medi-Cal
- ☐ Self Pay (bill patient)
- ☐ Private Pay/PPO

Other: _____

Insurance Information (please attach copy of insurance card, front & back):

Insurance Co. Name: _____

Member/Insured ID #: _____ Group #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

MediCare #: _____ Suffix: _____

MediCal #: _____

ICD-10 DIAGNOSIS CODE: **REQUIRED**

Pap Smear - Medicare/Medi-Cal - Please check ONE:
- ☐ Screening Pap: **routine** (reimbursable once every 2 yrs)
- ☐ Screening Pap: **high risk** factor: _____
- ☐ Diagnostic Pap: **history** of abnormality or signs of symptoms of medical necessity (ICD-10 code to left)
- ☐ Pap Smear: **non-covered** services (attach signed ABN)

NOTE: All slides must be labeled in pencil with patient's full name. All specimen containers must be labeled with: (1) Patient's Full Name (2) Source of the specimen it contains (3) 2nd Patient ID (eg. MRN, DOB). The lab will reject all unlabeled slides/specimens.

Gyn Cytology:

PAP: ☐ ThinPrep Pap Other: _____
☐ Conventional Pap Smear

SOURCE: ☐ Cervical/Endocervical
☐ Vaginal Other: _____

LMP: _____

Prev. ACC #: _____ Date: _____

Diagnosis: _____

Check all that apply:
- ☐ Routine Pap
- ☐ Pregnant
- ☐ Post-Partum
- ☐ Post-Menopausal
- ☐ Abnormal Bleeding
- ☐ Total Hysterectomy
- ☐ Partial Hysterectomy (Cervix in Place)
- ☐ BCP
- ☐ Depo-Provera
- ☐ Hormones
- ☐ IUD
- ☐ Leep/Cone
- ☐ Chemo/Rad

SCMG Pap Smears:
- ☐ Routine Pap (≥ 25 yr old)
- ☐ Routine Pap & Chlamydia (16-24 yo)

Molecular Pathology:

HPV (High Risk):
- ☐ Reflex ASCUS
- ☐ Reflex ASCUS and above
- ☐ HPV (Regardless of pap)
- ☐ HPV Only (No pap)
- ☐ HPV 16/18 reflex if ASCUS
- ☐ HPV 16/18 reflex if positive HPV
- ☐ HPV 16/18Hi

CT/NG:
- ☐ CT/NG (Both)
- ☐ Chlamydia (Only)
- ☐ N. gonorrhea (Only)

Other:
- ☐ Trichomonas

Non-Gynecological Cytology:

Lt	Rt				
☐	☐	☐ Thyroid FNA	☐ Cystic	☐ Solid	
☐	☐	☐ Breast FNA			
☐	☐	☐ Breast Halo			
☐	☐	☐ Nipple Discharge			
☐	☐	☐ L.Node FNA Site: _____			
☐	☐	☐ Pleural Fluid			
☐	☐	☐ Bronchial Washing			
☐	☐	☐ Bronchial Brushing			
		☐ Sputum	☐ Expectr	☐ Induced	
		☐ Peritoneal Fluid			
		☐ Peritoneal Washing			
		☐ CSF			
		☐ Urine	☐ Voided	☐ Cathet	
☐	☐	☐ Other, specify source and method:			

Surgical Biopsy/Tissue: Biopsy Site(s) - please list: *(Please specify the site of each biopsy)*

1)	3)	5)
2)	4)	6)

Clinical Diagnosis, Pertinent History and Operative Findings and Additional Requests:

_____

_____

_____

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