Jump to:

How to Request Laboratory Services

All requests for laboratory tests or services should be requested by a healthcare provider and the orders recorded in the patient's medical record. Requests for laboratory services or tests can be made by using the hospital's Cerner Information System (CIS), the laboratory information system (LIS) and/or by completing the appropriate paper requisition. Manual requisitions will be the required method of requesting laboratory services during times that computer order entry is not available.

The following information is required for each request (failure to properly supply the following information may result in delays in test analysis or in the rejection of the specimen):

Patient Information (required)

- Full name
- Hospital Medical Record Number
- Location (unit, clinic, room, etc)
- Attending or referring physician
- Age, date of birth, sex, and race
- Financial Number or Outreach Account #

Test Information (required)

- Test(s) requested
- Date and time of specimen collection
- Identity of person collecting the specimen
- Test urgency level (designate Routine or STAT)
- Other information (ie, specimen source, drug dosage information, comments)

Other Clinical Information (as requested)

[Go to Top]

- Diagnosis (appropriate ICD-9 Code or narrative description)
- Menstrual history
- Current medications
- Pre-op diagnosis
- Justification for request

Billing Information (required)

We need to assure that we have complete patient billing information to process claims to third party payers and to satisfy Medicare requirements. The additional pieces of information listed below are essential for billing. Please include this information with a copy of the patient's insurance cards and attach to requisition.

- Address
- Phone number
- Date of Birth, or another secondary patient identifier
- Marital status
- Guarantor's name and phone number (if not the patient)
- Insurance Policy/Group Number/ Subscriber (member) Number
- Requesting physician's name and UPIN (unique physician identification number)
- ICD-9 diagnosis code or narrative description

Outreach Referrals on Inpatients: For established outreach accounts with hospitals in the community, the patient’s sample should be accompanied by a VCUHS Outreach requisition clearing indicating that the account should be billed.

Instructions for Completing Patient Information Portion of Requisition:

1. Complete the patient information section with patient's full name, secondary patient identifier or medical record number, date of birth, sex, race, height and weight.
2. The specimen collection information should be completed with the date and time of collection, and the test priority level.

    - Please indicate specimen type, as well as the source, and whether a serum sample is a fasting specimen.
    - Indicate where the report should be called if requested (include phone number).

3. Each test must be associated with a Diagnosis/ICD-9 code. Please list all Diagnosis/ICD-9 codes pertaining to this visit and indicate beside the test the diagnosis associated with it.

4. Complete Planned Admission section.

    - Answer the question “Is there a planned admission within the next three days?” If yes, please provide name of hospital. Indicate responsible party for billing.
    - If the patient is currently an Inpatient, please note and mark bill to account.

5. Each test must be associated with a Diagnosis/ICD-9 code. Please list all Diagnosis/ICD-9 codes pertaining to this visit and indicate beside the test the diagnosis associated with it.

REQUESTS FOR PRIORITY (STAT) SERVICES

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The request for urgent collection, transport, analysis, and reporting of tests may be critical for proper patient care. Careful consideration should be given when requesting any service or test on a stat basis since misuse of this service may affect other patient services increasing the overall cost of patient care. The clinical use of this stat/priority service and the laboratory's performance are metrics used and reported in the Department of Pathology Quality Management Program.

STAT: A request in which all possible speed and prioritization is used to analyze and report results to a physician who requires the information and is waiting to make an urgent patient care decision. Most test results are available within 1 hour and are immediately phoned or transmitted electronically to the physician or unit. Stat or Priority must be indicated on the accompanying requisition. Refer to Stat Test List in the Appendices of this publication.

Routine: A request for laboratory tests on patients from a ward or clinic, in which the test will be analyzed at the earliest possible time (which for most tests is within 4-6 hours or the same day) and which will be reported through the routine reporting systems (see Result Reporting Section). The actual turnaround time for routine test requests depends on the test and time of day of specimen receipt. It is expected that the majority of test requests should be with this level of urgency. Specific information is available in the Alphabetical Listing of Tests.

Laboratory Result Turnaround Time (TAT): The laboratory attempts to comply with the TAT as described in the laboratories Production Schedule for each test. The laboratory's Quality Management program monitors this performance and requires at least a 90% compliance rate with these performance standards. Contact the laboratory if problems with TAT are detected.

TESTS NOT LISTED IN CATALOG

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When a specific test is not included in the catalog of services, healthcare providers should contact the laboratory's Client Services Help-Line at 828-7284 to determine if the analysis is performed by Pathology or VCUHS, or if the test is referred to a commercial reference laboratory.

New tests or tests not listed in the handbook may be ordered by entering a Type-In order in the hospital's CIS or by completing a manual requisition and listing the specific test/service required, and other pertinent patient and specimen information. Before requesting miscellaneous tests, contact the laboratory Helpline to ensure that the laboratory does not currently perform the test. The Department of Pathology continuously reviews referral testing to develop and bring new procedures in house whenever volume dictates or the addition of the testing is otherwise justified. Please contact Pathology Administration and faculty for consultation about the availability of new procedures.

VCUHS: General Lab Manual (Downtime) Request Internal Use Only

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VCU Health System
MCV Hospitals and Physicians

MCV Hospitals & Physicians of the VCU Health System
Clinical Pathology Laboratory Requisition
403 North 13th Street, CSC Building (6th Floor) • Richmond, VA 23298 • Phone (804) 828-7284 (PATH)

MEDICAL RECORD NUMBER | SSN | MCVH PATIENT LOCATION | LOCATION PHONE # | ☐ CALL REPORT #
PATIENT NAME: LAST | FIRST | MI | DOB | SEX | ☐ INPATIENT ☐ OUTPATIENT
ADDRESS | CITY | STATE | ZIP | PHONE
INSURANCE COMPANY NAME | SUBSCRIBER NO. | GROUP NO.
INSURER ADDRESS | SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ OTHER | PROVIDER NAME
MEDICARE NO. ☐ PRIMARY ☐ SECONDARY* *HAVE YOU COMPLETED THE MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE ☐ YES ☐ NO | MEDICAID NO.
FOR OUTPATIENTS ONLY: IS THERE A PLANNED HOSPITAL ADMISSION WITHIN THE NEXT THREE DAYS? ☐ NO ☐ YES, IF YES PROVIDE NAME OF HOSPITAL
SPECIMEN DATE: | COLLECTION TIME: | URINE: 24 HR VOLUME | SPECIMEN SOURCE

R	S	CHEMISTRY	ICD-9 Code
		Albumin	
		Alkaline Phosphatase*	
		ALT (SGPT)*	
		Amylase*	
		AST (SGOT)*	
		B12	
		Basic Metabolic Panel*	
		Bilirubin, direct	
		Bilirubin, total	
		CA 125	
		Calcium*	
		CEA	
		Chloride*	
		Cholesterol	
		CK MB Mass*	
		CK Total*	
		CO2*	
		Comprehensive Metabolic Panel	
		Creatinine*	
		Electrolytes Panel*	
		Ferritin	
		Folate	
		GGT	
		Glucose*	
		HCG Quant*	
		HCG Screen*	
		HDL Cholesterol	
		Hepatic Function Panel	
		Hydroxyethylated A1C	
		Iron	
		LD	
		LDL Cholesterol, direct	
		Lipase*	
		Lipid Profile	
		Magnesium*	
		Myoglobin*	
		Phosphorus	
		Potassium*	
		PSA	
		Sodium*	
		T Uptake	
		Thyroxine	
		Total Protein*	
		Transferrin	
		Triglycerides	
		Troponin I*	
		TSH	
		Urea Nitrogen*	
		Uric Acid	
		ADDITIONAL TESTS	

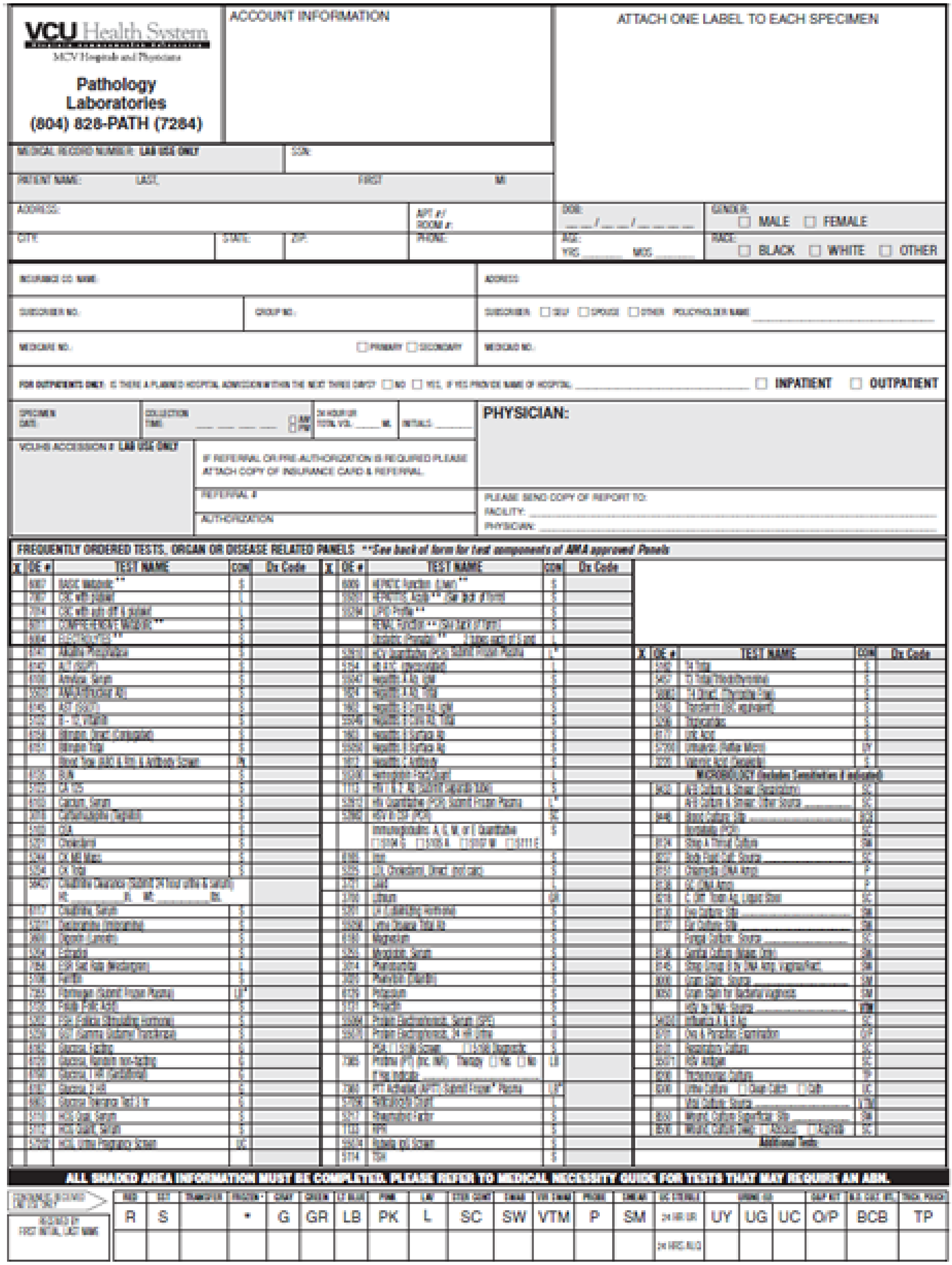
R	S	HEMATOLOGY	ICD-9 Code
		CBC with autodiff & platelet*	
		CBC with platelet*	
		Cell Count with diff __ CSF __ other*	
		Crystal identification, joint fluid*	
		ESR (anisergram)	
		Reticulocyte count	
		Sickle cell test	
		Urinalysis*	
		Urine Pregnancy test*	
		COAGULATION	
		Activated Protein C Resistance Screen	
		Activated PTT*	
		Antithrombin Activity	
		Circulating Anticoagulant	
		D-Dimer quant*	
		Factor Assay-I through XIII (please specify)	
		Fibrinogen*	
		Inhibitor Screen	
		Inhibitor titer	
		Lupus anticoagulant panel	
		Platelet aggregation (call lab to schedule)	
		Protein C activity	
		Protein S activity	
		Prothrombin time (PT)*	
		Thrombin time	
		von Willebrand's Factor Antigen	
		von Willebrand's Factor Assay	
		TOXICOLOGY	
		Alcohol scan*	
		Amitriptyline	
		Blood lead & ZPP	
		Carbamazepine*	
		Dilantin*	
		Digoxin*	
		Drugs of Abuse (urine) (DAU STAT)*	
		Ethylene Glycol	
		Gabapentin	
		Gastric lavage/rectal drug screen (Screen GU)*	
		Imipramine	
		Lamotrigine	
		Nortriptyline	
		Phenobarbital*	
		Phenytoin*	
		Topiramate	
		Valproic Acid*	
		MOLECULAR DIAGNOSTICS	
		CMV Quantitative	
		HCV Genotyping	
		HCV Quantitative	
		HIV Genotyping	
		HIV Quantitative	
		Factor V Leiden Mutation	

R	S	MICROBIOLOGY / IMMUNOLOGY	ICD-9 Code
		Anaerobic & aerobic culture & sensitivity (provide source)	
		AFB culture & smear	
		ANA (antinuclear Ab)	
		Bacterial culture & sensitivity (provide source)	
		C. trachomatis (DNA Amplification)	
		FTA ABS	
		Fungal Culture	
		Gram Stain*	
		Hepatitis A Ab IgM	
		Hepatitis A Total Ab (IgG & IgM)	
		Hepatitis B Core Ab IgM	
		Hepatitis B E Ab	
		Hepatitis B S Ag	
		Hepatitis B Total core Ab (IgG & IgM)	
		Hepatitis C Ab	
		HIV 1 & 2 AB	
		HSV any culture	
		Immunofixation electrophoresis	
		Immunoglobulin A, G, M quant. Specify	
		Immunoglobulin IgE quant	
		Influenza A Ag*	
		Lyme Disease Total Ab	
		N. gonorrhoeae (NG) (DNA Amplification)	
		Ova & Parasites Examination	
		Rheumatoid Factor	
		Rocky Mt. Spotted Fever Ab	
		Rotavirus Ag	
		RPR	
		RSV Ag*	
		Rubella IgG screen	
		Serum protein electrophoresis	
		Strep A Ag screen*	
		Urine colony count culture	
		Urine protein electrophoresis	
		Viral culture, comprehensive	
		FLOW CYTOMETRY	
		CD4/CD8 (Help./Supp. Ratio)	
		Acute Leukemia Panel	
		Lymphocyte Enumeration Panel	
		Lymphocytosis Panel	
		Other Markers, specify	
		BLOOD BANK	
		Antibody Screen	
		Blood Type	
		Compatibility Test (cross match) # units	
		DAT (Direct Coombs)	
		Fetal RBC Screen	
		Isoimmune Antibody Titer	
		RhIG (Rhesus Globulin)	

Requesting Physician (Print) | Physician's Signature | Date

All shaded area information must be completed. Please indicate R for routine or S for STAT (Note only tests that have an * may be ordered STAT). Please refer to Medical Necessity Guide for tests that may require an ABN.
59-316 (08/03) Lab Copies - White/Yellow/Pink Originating Location Copy - Gold

VCUHS Outreach Client: General Lab Request [Go to Top]



Anatomic Pathology Requisition Instructions [Go to Top]

1. Complete the following patient demographic information: patient's name, address, telephone number, date of birth, sex, race, and other secondary patient identifier. If the patient is receiving services at VCUHS, enter medical record number.
2. Provide the patient's VCUHS service location (floor, room, clinic etc).
   If the patient's sample is referred from outside the VCUHS environment, enter the referring institution. Check the appropriate box for inpatient or outpatient. Enter referring physician name and UPIN number and/or ordering physician name UPIN number.
3. Enter current specimen date: (month, date, year).
4. Complete the Planned Hospital Admission section if appropriate.

   - Answer the question "Is there a planned admission within the next three days?" If yes, provide name of hospital.

5. If final report is to be faxed, answer yes or no.

   - Include mailing address, fax number, telephone number.
   - If within VCUHS, provide delivery location for report to be hand delivered.

6. Attach patient demographic registration form to back of requisition or manually complete all appropriate insurance/billing information. An appropriate **ICD-9 code for the procedure is required.**
7. Enter the date and time of specimen collection and the sources of the specimens being submitted.
8. Enter all required significant clinical information such as preop or postop diagnosis.

VCUHS Internal Use Only:
Surgical Pathology - Manual Request

[Go to Top]

VCU Health System
MCV Hospitals and Physicians

VCU Health System / MCV Hospitals & Physicians
Richmond, VA 23298 • Phone (804) 828-7284 (PATH)
ANATOMIC PATHOLOGY

PLACE STAMP OR LABEL HERE

ACCESSION #

REFERRING PHYSICIAN:

INSURANCE PRE-AUTHORIZATION #:

MEDICAL RECORD NUMBER | SSN | PATIENT LOCATION | LOCATION PHONE NO.

PATIENT NAME LAST FIRST M | DOB | SEX | ☐ INPATIENT ☐ OUTPATIENT

ADDRESS | CITY | STATE | ZIP | PHONE

INSURANCE CO. NAME | SUBSCRIBER NO. | GROUP NO.

INSURER ADDRESS | SUBSCRIBER PROVIDE NAME ☐ SELF ☐ SPOUSE ☐ OTHER

MEDICARE NUMBER ☐ PRIMARY ☐ SECONDARY* | * HAVE YOU COMPLETED THE MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE? ☐ YES ☐ NO | MEDICAID NO.

FOR OUTPATIENTS ONLY: IS IT FULL A PLANNED HOSPITAL ADMISSION WITHIN THE NEXT THREE DAYS? ☐ NO ☐ YES IF YES PROVIDE NAME OF HOSPITAL

REPORT SHOULD BE SENT TO (*PLEASE ENTER MCV DELIVERY LOCATION, FAX #, TELEPHONE #, OR MAILING ADDRESS*):

1. 2. 3.

LIST SOURCES OF SPECIMENS BELOW:

DATE/TIME COLLECTED:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

SIGNIFICANT CLINICAL DATA REQUIRED

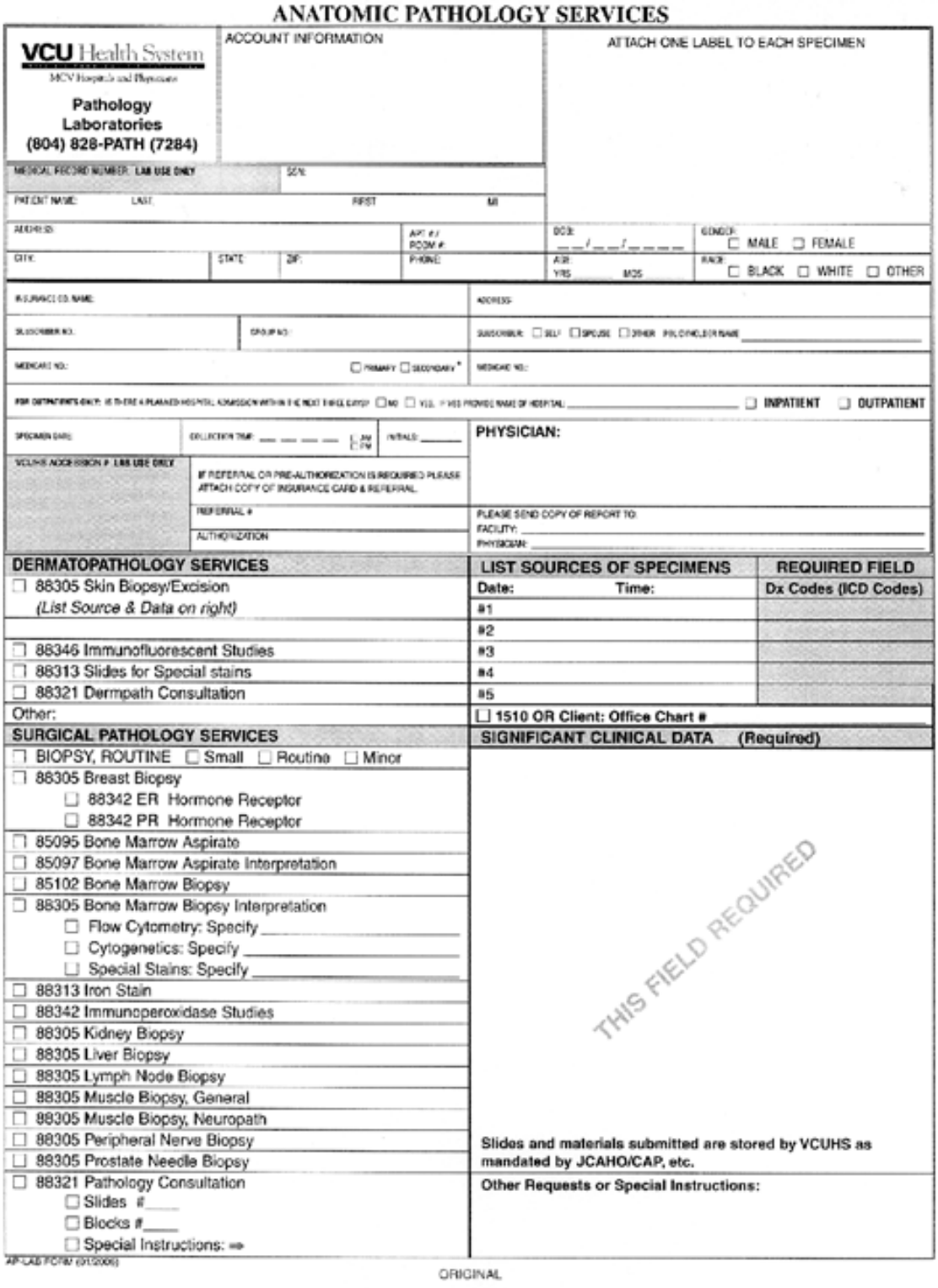
ICD-9 CODE REQUIRED

MEDICAL RECORDS COPY

87-180 (01/02) PAGE 1

VCUHS Outreach Client: Surgical Pathology Request

[Go to Top]



ANATOMIC PATHOLOGY SERVICES

VCU Health System
MCV Hospitals and Physicians

Pathology Laboratories
(804) 828-PATH (7284)

ACCOUNT INFORMATION

ATTACH ONE LABEL TO EACH SPECIMEN

MEDICAL RECORD NUMBER: LAB USE ONLY | SEX

PATIENT NAME: LAST FIRST MI

ADDRESS | APT # / ROOM # | DOB: ___/___/_____ | GENDER: ☐ MALE ☐ FEMALE

CITY | STATE | ZIP | PHONE | AGE: YRS MOS | RACE: ☐ BLACK ☐ WHITE ☐ OTHER

INSURANCE CO. NAME | ADDRESS

SUBSCRIBER NO. | GROUP NO. | SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ OTHER POLICYHOLDER NAME

MEDICARE NO: ☐ PRIMARY ☐ SECONDARY* | MEDICAID NO.:

FOR OUTPATIENTS ONLY: IS THIS FOR A PLANNED HOSPITAL ADMISSION WITHIN THE NEXT 5 MILL DAYS? ☐ NO ☐ YES, IF YES PROVIDE NAME OF HOSPITAL _____ ☐ INPATIENT ☐ OUTPATIENT

SPECIMEN DATE | COLLECTION TIME: ___ ___ ___ ___ ☐ AM ☐ PM | INITIALS: _____

PHYSICIAN:

VCUHS ACCESSION # LAB USE ONLY

IF REFERRAL OR PRE-AUTHORIZATION IS REQUIRED, PLEASE ATTACH COPY OF INSURANCE CARD & REFERRAL

REFERRAL # | AUTHORIZATION

PLEASE SEND COPY OF REPORT TO:
FACILITY: _____
PHYSICIAN: _____

DERMATOPATHOLOGY SERVICES	LIST SOURCES OF SPECIMENS	REQUIRED FIELD
☐ 88305 Skin Biopsy/Excision *(List Source & Data on right)*	Date: Time:	Dx Codes (ICD Codes)
	#1	
	#2	
☐ 88346 Immunofluorescent Studies	#3	
☐ 88313 Slides for Special stains	#4	
☐ 88321 Dermpath Consultation	#5	
Other:	☐ 1510 OR Client: Office Chart #	

SURGICAL PATHOLOGY SERVICES	SIGNIFICANT CLINICAL DATA (Required)
☐ BIOPSY, ROUTINE ☐ Small ☐ Routine ☐ Minor	THIS FIELD REQUIRED
☐ 88305 Breast Biopsy	
☐ 88342 ER Hormone Receptor	
☐ 88342 PR Hormone Receptor	
☐ 85095 Bone Marrow Aspirate	
☐ 85097 Bone Marrow Aspirate Interpretation	
☐ 85102 Bone Marrow Biopsy	
☐ 88305 Bone Marrow Biopsy Interpretation	
☐ Flow Cytometry: Specify _____	
☐ Cytogenetics: Specify _____	
☐ Special Stains: Specify _____	
☐ 88313 Iron Stain	
☐ 88342 Immunoperoxidase Studies	
☐ 88305 Kidney Biopsy	
☐ 88305 Liver Biopsy	
☐ 88305 Lymph Node Biopsy	
☐ 88305 Muscle Biopsy, General	
☐ 88305 Muscle Biopsy, Neuropath	
☐ 88305 Peripheral Nerve Biopsy	
☐ 88305 Prostate Needle Biopsy	Slides and materials submitted are stored by VCUHS as mandated by JCAHO/CAP, etc.
☐ 88321 Pathology Consultation	Other Requests or Special Instructions:
☐ Slides #____	
☐ Blocks #____	
☐ Special Instructions: ⇒	

AP-CASE FORM (01/2006)

ORIGINAL

VCUHS Internal Use Only:
Cytology Manual (Downtime) Request

[Go to Top]

CYTOPATHOLOGY SERVICES

Name _____
Address _____
_____ Zip _____
Birthdate _____ Sex ☐ M ☐ F
Chart # _____
Social Security No. _____

Medical College of Virginia Hospitals
Virginia Commonwealth University
DIVISION OF SURGICAL & CYTOPATHOLOGY
Richmond, Virginia 23298

Requesting MD _____
Address _____
Phone/Beeper _____
Date: ____ / ____ / ____
Body Site: _____

Is there a planned admission within the next three days?
☐ No ☐ Yes **Provide Hospital** _____

Indicate Patient Location: ☐ Consult _____
☐ InPt _____ CT OR
☐ OutPt _____

Dx of Malignant Neoplasm	199.1 ☐
Dx of Benign Neoplasm	229.9 ☐
Dx of Unspecified Neoplasm	239.9 ☐
Dx of Infectious Disease	088.9 ☐

Insurance Co. _____
Policy # _____

SPECIAL REQUEST HORMONE EVAL. _____ IMPORTANT CLINICAL HISTORY
OTHER _____
DATE OF LMP _____
RADIATION THERAPY DATE, TYPE, AMOUNT _____
ENDOCRINE THERAPY _____

CYTOPATHOLOGIC INTERPRETATION:

☐ NEGATIVE *Malignant Tumor Cells Are Not Identified*
☐ WNL *Within Normal Limits*
☐ smear not entirely satisfactory due to
☐ smear entirely unsatisfactory

☐ Limited Cells ☐ No Endocx Sample
☐ Dry Artifact ☐ No Vaginal Pool
☐ Exudate ☐ Not a Deep Cough
☐ Degeneration ☐ Excessive Blood
☐ No LMP Given ☐ No Age Given

CELLULAR CHANGES PRESENT CONSISTENT WITH:

Cervicitis - Mild Moderate Severe
Squamous Metaplasia
☐ **BCC Benign Cellular Changes**
- **Atypical Cells of reparative/inflammatory process**
- **Reactive endocervical cells**

Organisms - Trichomonas Candida Bacterial Vaginosis
☐ **ECA Epithelial Cell Abnormality**
- **ASCUS - Atypical squamous cells of undetermined significance**
- **LGSIL - Low grade squamous intraepithelial lesion, CIN I**
- **Human Papilloma Virus, Cytopathic effect**
- **HGSIL - High grade squamous intraepithelial lesion, CIN II, CIN III**

OTHER _____

RECOMMENDATION: ☐ None ☐ Immediate Repeat Smear ☐ Repeat Smear in _____ Months / Year(s)
To Include:
☐ Biopsy ☐ Other _____ ☐ Endocervical Sample
☐ Cone ☐ D & C ☐ Endometrial Sample

CYTOTECH: _____ DATE: _____ SIGNED: _____ M.D.
NAME (PRINT)

DISCLAIMER: Cervical/vaginal cytology is a screening test with a recognized false negative rate. New technologies may decrease but will not eliminate false negative results. Regular (generally annual) cytology screening is recommended to minimize false negative results.

MEDICARE ADVANCE BENEFICIARY NOTICE - SCREENING PAP SMEARS

Because the screening Pap Smear is a Medicare Frequency - Limited Service the ABN may be used routinely by having the Medicare Beneficiary Sign either of the two applicable agreements shown below.

Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare programs, Medicare will deny payment for a ***Screening Pap Smear if you have had one during the last three (3) years.***

BENEFICIARY AGREEMENT: "I have been notified by my ***physician/laboratory*** that Medicare will deny payment for a ***Screening Pap Smear if I have had one during the last three (3) years.*** I believe that I have not had / have had (***CIRCLE ONE***) a ***Screening Pap Smear during the last three (3) years.*** If I am mistaken and Medicare denies payment, I agree to be personally and fully responsible for payment.

_____
Beneficiary Signature

57-049 (5/98)

VCUHS Outreach Client: Cytology Request

[Go to Top]

CYTOPATHOLOGY SERVICES

VCU Health System
MCV Hospitals and Physicians

Pathology
Laboratories
(804) 828-PATH (7284)

ACCOUNT INFORMATION

ATTACH ONE LABEL TO EACH SPECIMEN

MEDICAL RECORD NUMBER: LAB USE ONLY | SSN:

PATIENT NAME: LAST, FIRST MI

ADDRESS: | APT # / ROOM #: | DOB: ___/___/___ | GENDER: ☐ MALE ☐ FEMALE

CITY: | STATE: | ZIP: | PHONE: | AGE: YRS _____ MOS _____ | RACE: ☐ BLACK ☐ WHITE ☐ OTHER

INSURANCE CO. NAME: | ADDRESS:

SUBSCRIBER NO.: | GROUP NO.: | SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ OTHER POLICYHOLDER NAME: _____

MEDICARE NO.: ☐ PRIMARY ☐ SECONDARY | MEDICAID NO.:

FOR OUTPATIENTS ONLY: IS THERE A PLANNED HOSPITAL ADMISSION WITHIN THE NEXT THREE DAYS? ☐ NO ☐ YES, IF YES PROVIDE NAME OF HOSPITAL: _____ ☐ INPATIENT ☐ OUTPATIENT

SPECIMEN DATE: | COLLECTION TIME: ___:___ ☐ AM ☐ PM | 24 HOUR UR TOTAL VOL. _____ mL | INITIALS: _____

PHYSICIAN:

VCUHS ACCESSION # LAB USE ONLY

IF REFERRAL OR PRE-AUTHORIZATION IS REQUIRED PLEASE ATTACH COPY OF INSURANCE CARD & REFERRAL.

REFERRAL #

AUTHORIZATION

PLEASE SEND COPY OF REPORT TO:
FACILITY: _____
PHYSICIAN: _____

Non-Gynecological Services	DX CODE
☐ Body Cavity / Fluid Washing	
☐ CSF	
☐ Fine Needle Aspiration: Source_____	
☐ Nipple Discharge	
☐ Ocular Cytology	
☐ Oral Cavity Cytology (Direct Smear)	
Respiratory Cytology	
☐ Bronchial Brushing	
☐ Bronchial Washing	
☐ Bronchoalveolar Lavage (BAL)	
☐ Sputum Cytology	
Urinary Cytology	
☐ Bladder Washing	
☐ Urethral Cytology	
☐ Urine, Catheterized	
☐ Urine, Voided	
Gynecological Cytology Services	
☐ Pap Smear (1 Slide)	
☐ Pap Smear (2 Slide)	
☐ Liquid Based Pap (Surepath-**Blue Cap Vial**)	
☐ HPV Hybrid Capture (Reflex with ASCUS)	
☐ HPV Hybrid Capture (DNA Assay-any diagnosis)	
☐ HPV Hybrid Capture Only (**Blue Cap Vial**)	

☐ 1510 OR Client:
Office Chart # _____

IMPORTANT CLINICAL HISTORY

THIS FIELD REQUIRED

Other: _____

Date of LMP: _____

Radiation Therapy:
Date: _____
Type: _____
Amount: _____

Endocrine Therapy:_____

All shaded area information must be completed. Complete all pertinent clinical information and history with sample submission.

MEDICARE ADVANCE BENEFICIARY NOTICE - SCREENING PAP SMEARS

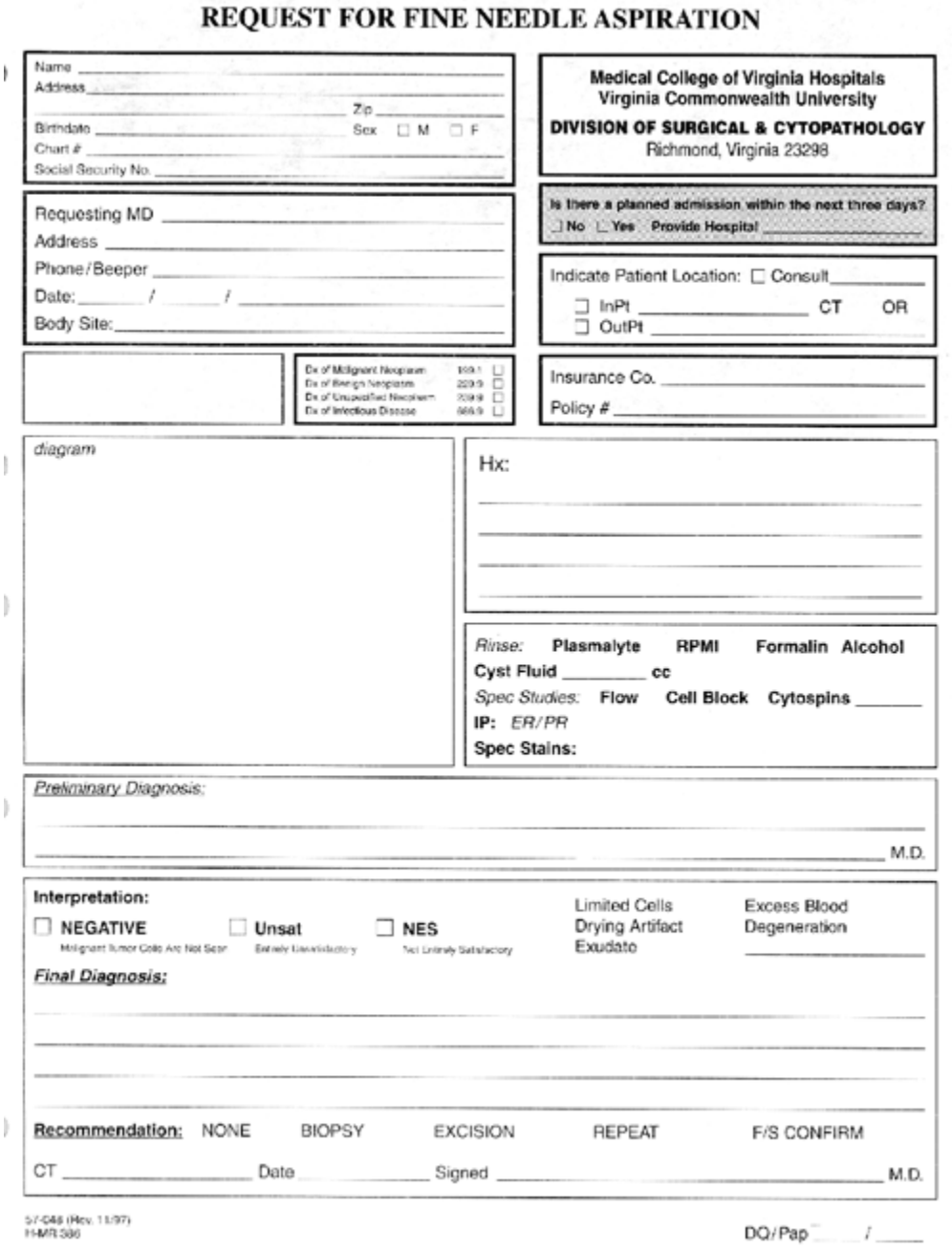
Because the screening Pap Smear is a Medicare Frequency - Limited Service the ABN may be used routinely by having the Medicare Beneficiary Sign either of the two applicable agreements shown below. Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare programs, Medicare will deny payment for a ***Screening Pap Smear if you have had one during the last three (3) years.***

BENEFICIARY AGREEMENT: I have been notified by my *physician/laboratory* that Medicare will deny payment for a ***Screening Pap Smear if I have had one during the last three (3) years.*** I believe that I have not had / have had (***CIRCLE ONE***) a ***Screening Pap Smear during the last three (3) years.*** If I am mistaken and Medicare denies payment, I agree to be personally and fully responsible for payment.

Beneficiary Signature _____

VCUHS Internal Use Only:
Manual (Downtime) Request

[Go to Top]



REQUEST FOR FINE NEEDLE ASPIRATION

Name _____
Address _____
_____ Zip _____
Birthdate _____ Sex ☐ M ☐ F
Chart # _____
Social Security No. _____

Medical College of Virginia Hospitals
Virginia Commonwealth University
DIVISION OF SURGICAL & CYTOPATHOLOGY
Richmond, Virginia 23298

Requesting MD _____
Address _____
Phone/Beeper _____
Date: ____ / ____ / _____
Body Site: _____

Is there a planned admission within the next three days?
☐ No ☐ Yes Provide Hospital _____

Indicate Patient Location: ☐ Consult _____
☐ InPt _____ CT OR
☐ OutPt _____

Dx of Malignant Neoplasm 199.1 ☐
Dx of Benign Neoplasm 229.9 ☐
Dx of Unspecified Neoplasm 239.9 ☐
Dx of Infectious Disease 999.9 ☐

Insurance Co. _____
Policy # _____

diagram

Hx:

Rinse: **Plasmalyte RPMI Formalin Alcohol**
Cyst Fluid _____ **cc**
Spec Studies: **Flow Cell Block Cytospins** _____
IP: *ER/PR*
Spec Stains:

Preliminary Diagnosis:

_____ M.D.

Interpretation:
☐ **NEGATIVE** Malignant Tumor Cells Are Not Seen ☐ **Unsat** Extremely Unsatisfactory ☐ **NES** Not Entirely Satisfactory

Limited Cells
Drying Artifact
Exudate

Excess Blood
Degeneration
_____

Final Diagnosis:

Recommendation: NONE BIOPSY EXCISION REPEAT F/S CONFIRM

CT _____ Date _____ Signed _____ M.D.

5/7-048 (Rev. 11/97)
HMR 386

DQ/Pap ____ / ____