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)
How to Request Laboratory Services

Other Clinical Information (as requested)

- 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

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

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.
How to Request Laboratory Services

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

<table>
<thead>
<tr>
<th>SPHOBIE (DATE)</th>
<th>COLLECTION TIME</th>
<th>SPECIMEN (VOLUME)</th>
<th>SPECIMEN (SOURCE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>S</td>
<td>CHEMISTRY</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>01/01/2023</td>
<td>09:00 AM</td>
<td>Complete Blood Count</td>
<td>190.580</td>
</tr>
<tr>
<td>01/02/2023</td>
<td>09:00 AM</td>
<td>Chemist Estimation</td>
<td>190.580</td>
</tr>
<tr>
<td>01/03/2023</td>
<td>09:00 AM</td>
<td>Hemoglobin</td>
<td>190.580</td>
</tr>
</tbody>
</table>

Requesting Physician: [signature]
VCUHS Outreach Client: General Lab Request

---

### Account Information

- **Address:** [Redacted]
- **Insurance Co. Name:** [Redacted]
- **Subscriber No.:** [Redacted]
- **Group No.:** [Redacted]
- **Subscriber:** [Redacted]
- **Subscriber Name:** [Redacted]
- **Provider Name:** [Redacted]

### EBMUH Accession 

- **Test Name:** [Redacted]
- **Description:** [Redacted]
- **Test Code:** [Redacted]

### Frequently Ordered Tests Ovarian Disease Related Panels

<table>
<thead>
<tr>
<th>Test Code</th>
<th>Test Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>123</td>
<td>Test A</td>
</tr>
<tr>
<td>456</td>
<td>Test B</td>
</tr>
</tbody>
</table>

---

### Physician Information

- **Physician:** [Redacted]

---

### Additional Instructions

- **Please send copy of report to:** [Redacted]
- **Authorization:** [Redacted]
Anatomic Pathology Requisition Instructions

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
# How to Request Laboratory Services

## VCUHS Outreach Client: Surgical Pathology Request

**ANATOMIC PATHOLOGY SERVICES**

**ACCOUNT INFORMATION**

**Pathology Laboratories**  
(804) 828-PATH (7284)

**MEDICAL RECORD NUMBER: **

**LAB USE ONLY**

**PATIENT NAME:**

**LAST**

**FIRST**

**ADDRESS:**

**STREET**

**CITY**

**STATE**

**ZIP**

**DATE:**

**AP/RO#**

**ROOM #**

**F-PROC #**

**DOB:**

**GENDER:**

**SEX:**

**RACE:**

**RELATIONSHIP:**

**MEDICAL NARRATIVE:**

**PHYSICIAN:**

**SPECIMEN DATE:**

**COLLECTION TIME:**

**PHYSICIAN:**

**SPECIMEN:**

**SOURCE:**

**DESCRIPTION:**

**RECIPIENT:**

**INSTITUTION:**

**DATE:**

**TIME:**

**DX CODES (ICD CODES):**

**SIGNIFICANT CLINICAL DATA:**

**PROTOCOL:**

**SLIDES AND MATERIALS SUBMITTED:**

**SPECIAL INSTRUCTIONS:**

**OTHER Requests:**

**Special Instructions:**

**Slides and materials submitted are stored by VCUHS as mandated by JCAHO/CAP, etc.**

**Slides: # **

**Blocks: # **

**Special Instructions: **

**ORIGINAL**
### How to Request Laboratory Services

#### VCUHS Internal Use Only: Cytology Manual (Downtime) Request

![Cytology Manual Form](image)

**Name:**

**Address:**

**Birthdate:**

**Chart #:**

**Social Security No.:**

**Requesting MD:**

**Address:**

**Phone/Beeper:**

**Date:**

**Body Site:**

**Medical College of Virginia Hospitals**

**Virginia Commonwealth University**

**DIVISION OF SURGICAL & CYTOPATHOLOGY**

**Richmond, Virginia 23298**

**Is there a planned admission within the next three days?**

- [ ] No
- [ ] Yes

**Provide Hospital:**

**Indicate Patient Location:**

- [ ] Consult
- [ ] InP
- [ ] OutP
- [ ] CT
- [ ] OR

**Insurance Co.:**

**Policy #:**

---

**SPECIAL REQUEST HORMONE EVAL:**

**DATE OF LMP:**

**RADIATION THERAPY DATE, TYPE, AMOUNT:**

**ENDOCRINE THERAPY:**

---

**CYTOPATHOLOGIC INTERPRETATION:**

**NEGATIVE:**

- [ ] Malignant Tumor Cells Are Not Identified
- [ ] WNL
  - [ ] Within Normal Limits

**CELLULAR CHANGES PRESENT CONSISTENT WITH:**

- [ ] Cervicitis - Mild
- [ ] Moderate
- [ ] Severe

- [ ] Squamous Metaplasia
- [ ] DCC Benign Cellular Changes
  - [ ] Atypical Cells of reparative/inflammatory process
  - [ ] Reactive endocervical cells

**Organisms - Trichomonas Candida Bacterial Vaginosis**

- [ ] ASCUS - Atypical squamous cells of undetermined significance
- [ ] LSIL - Low grade squamous intraepithelial lesion, CIN I
- [ ] Human Papilloma Virus, Cytopathic effect
- [ ] HSIL - High grade squamous intraepithelial lesion, CIN II, CIN III

**RECOMMENDATION:**

- [ ] None
- [ ] Immediate Repeat Swab
- [ ] Repeat Swab in

**To Include:**

- [ ] Limited Cells
- [ ] No Endocervical Sample
- [ ] Dry Artifact
- [ ] No Vaginal Pool
- [ ] Exudate
- [ ] No LMP Given
- [ ] Degeneration
- [ ] Not a Deep Cough
- [ ] Excessive Blood
- [ ] No Age Given

**CYTOTEC:**

**DATE:**

**SIGNED:**

**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.

---

**MCDJ3CE3Z11**

**M.D.**

**MCDJ3CE3Z11**

**M.D.**

**Beneficiary Signature:**

**Beneficiary Signature:**

**Beneficiary Signature:**

---

**MEDICARE ADVANCE BENEFICIARY NOTICE - SCREENING PAP SMEARS**

Because the screening Pap Smear is a Medicare Benefit - Limited Service the ABN may be voided 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.

**BEFICIARY 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 a Pap test (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.
How to Request Laboratory Services

VCUHS Outreach Client: Cytology Request

## CYTOPATHOLOGY SERVICES

<table>
<thead>
<tr>
<th>ACCOUNT INFORMATION</th>
<th>ATTACH ONE LABEL TO EACH SPECIMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### VCU Health System

Pathology Laboratories
(804) 828-PATH (7284)

<table>
<thead>
<tr>
<th>Medical Record No.</th>
<th>NPI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Last:</th>
<th>First:</th>
<th>Middle:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race:</th>
<th>Ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider:</th>
<th>Primary/Secondary:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Office Chart #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IMPORTANT CLINICAL HISTORY

<table>
<thead>
<tr>
<th>Condition:</th>
<th>Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Non-Gynecological Services**

- Body Cavity / Fluid Washing
- CSF
- Fine Needle Aspiration: Source
- Nipple Discharge
- Ocular Cytology
- Oral Cavity Cytology (Direct Smeard)

**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 Slides)
- Pap Smear (2 Slides)
- 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)

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

Additional notes on request form: 

- Date of LMP: 
- Radiation Therapy: Date: Type: Amount: 
- Endocrine Therapy: 

---

**Beneficiary Agreement:** I have been notified by my physician and understand that Medicare will cover the costs for the above service(s) provided that the service(s) are reasonable and necessary for the diagnosis and treatment of my condition. Medicare may require payment for a family practice/specialty office visit. I am responsible for any Medicare co-payment. If I do not have Medicare, I understand that this service may not be covered by my private insurance. I have reviewed the above charges and understand that I am responsible for any portion of this charge not covered by my insurance or Medicare. I further understand that I have the right to refuse any portion of the Medicare or private insurance as a condition of treatment. I have signed this agreement voluntarily, without any pressure from VCU Health System.

---

**Signature:**
REQUEST FOR FINE NEEDLE ASPIRATION

Name ____________________________
Address __________________________
Birthdate __________________________ Sex: □ M □ F
Chart # ____________________________ Social Security No. __________________________

Requesting MD
Address __________________________
Phone/Beeper _______________________
Date: / / ____________________________

Body Site: __________________________

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

Is there a planned admission within the next three days?
□ No □ Yes. Provide Hospital __________________________

Indicate Patient Location: □ Consult
□ InPt ____________________________ CT OR
□ OutPt ____________________________

Insurance Co. ____________________________
Policy # ____________________________

Hx:

Spec studies: Flow Cyt Block Cytospins ____________

Preliminary Diagnosis: ____________________________

M.D.

Interpretation:
□ NEGATIVE □ Ursat □ NES

Limited Cells Drying Artifact
Exudate Excess Blod Degeneration

Final Diagnosis: ____________________________

M.D.

Recommendation: NONE BIOPSY EXCISION REPEAT F/S CONFIRM

CT Date Signed ____________________________

DQ/Pap ____________________________

Page 12 of 12