

# Anatomic Pathology Consultation Request Form

## Affiliated Pathologists, PA

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### PATIENT INFORMATION

AFFIX PATIENT LABEL HERE IF AVAILABLE

Name (Last, First MI): \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

SS # \_\_\_ - \_\_\_ - \_\_\_ MR# \_\_\_\_\_

Pt Address: \_\_\_\_\_

Pt Phone: \_\_\_\_\_

Submitting Physician: \_\_\_\_\_

Clinical Diagnosis (and/or ICD): \_\_\_\_\_

Pertinent Past History: \_\_\_\_\_

### SPECIMEN INFORMATION

Lab use:

Case # \_\_\_\_\_

Date Collected: \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_:

Procedure(s): \_\_\_\_\_

#### SURGICAL PATHOLOGY SPECIMENS

A. \_\_\_\_\_

F. \_\_\_\_\_

B. \_\_\_\_\_

G. \_\_\_\_\_

C. \_\_\_\_\_

H. \_\_\_\_\_

D. \_\_\_\_\_

I. \_\_\_\_\_

E. \_\_\_\_\_

J. \_\_\_\_\_

#### NON-GYN CYTOLOGY SPECIMENS

A. \_\_\_\_\_

C. \_\_\_\_\_

B. \_\_\_\_\_

D. \_\_\_\_\_

#### GYN CYTOLOGY SPECIMENS\*

(GYN specimens tested at **Anatomical Medical Laboratories, Inc**, Denton TX and/or Ardmore, OK, CLIA 45D4979106)

Gyn History: LMP: \_\_\_\_\_  PREGNANT  POST-PARTUM  POST-MENO  POST HYST.  ABN BLEEDING  DES  HRT  PREV ABN PAP

Source:  CERVICAL  ENDOCERVICAL  VAGINAL

Testing Requested:

- |  |  |
|--|--|
| <input type="checkbox"/> PAP Smear, Thin Layer with image analysis   | <input type="checkbox"/> PAP Smear, Thin Layer with image, Medicare** Routine Screen – 2yr   |
| <input type="checkbox"/> PAP Smear <input type="checkbox"/> 1 slide <input type="checkbox"/> 2 slides                    | <input type="checkbox"/> PAP Smear, Thin Layer with image, Medicare** High Risk – 1yr  |
| <input type="checkbox"/> PAP Smear + Maturation Index <input type="checkbox"/> 1 slide <input type="checkbox"/> 2 slides | <input type="checkbox"/> PAP Smear, Thin Layer with image, Medicare*** Diagnostic (Abn HX)   |
| <input type="checkbox"/> HPV typing, High Risk only, any diagnosis   | <input type="checkbox"/> PAP Smear, Medicare** Routine Screen - 2 yr <input type="checkbox"/> 1 slide <input type="checkbox"/> 2 slides  |
| <input type="checkbox"/> HPV typing, High Risk only, ASCUS/AGUS only   | <input type="checkbox"/> PAP Smear, Medicare** High Risk Screen - 1yr <input type="checkbox"/> 1 slide <input type="checkbox"/> 2 slides |
| <input type="checkbox"/> HPV typing, High Risk only, ASCUS or >  | <input type="checkbox"/> PAP Smear, Medicare*** Diagnostic (Abn HX)  |
| <input type="checkbox"/> Add Low Risk HPV typing to above  | <input type="checkbox"/> PAP Smear + Maturation Index, Medicare*** Diagnostic  |
| <input type="checkbox"/> GC/Chlamydia molecular testing  |  |

### BILLING INFORMATION [Attach copy of card(s) & information or complete.] BILL CLIENT/CLINIC

Responsible party: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Policy # \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Group number \_\_\_\_\_

Secondary coverage:

Insurance Co. \_\_\_\_\_

Policy # \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Group number \_\_\_\_\_

\*All PAP Smears subject to a pathology interpretation at an extra charge when performed

\*\*ABN required with each encounter for Medicare frequency limited PAP

\*\*\*Medicare Limited Coverage Test