Highlands Pathology Consultants, P.C.

www.highlandspath.com
2175 Hwy. 75, Suite 4, Blountville, TN 37617
Billing: 423-323-5290

ORDERING PHYSICIAN-LAST NAME, FIRST

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) | CHART #

PATIENT'S STREET ADDRESS | CITY, STATE, ZIP

PHONE # ( ) | DATE OF BIRTH / / | SEX M F | PATIENT'S I.D. | S.S.# (REQUIRED)

RESPONSIBLE PARTY | RELATIONSHIP TO PATIENT | SUBSCRIBER'S BIRTHDAY

INSURANCE COMPANY NAME (REQUIRED) | SECONDARY INSURANCE COMPANY NAME

ADDRESS | ADDRESS

CITY-STATE-ZIP CODE | CITY-STATE-ZIP CODE

POLICY I.D. NO. | SEQUENCE | GROUP NO. | POLICY I.D. NO. | SEQUENCE | GROUP NO.

ADDITIONAL REPORT COPIES

TO: _____

FAX REPORT TO:

ATTN: _____

FAX NO.

COLLECTION DATE/TIME: _____ AM PM PATIENT LOCATION: ☐ OFFICE ☐ SAME DAY SERVICES ☐ ER ☐ IN PATIENT ☐ OTHER _____

GYN CYTOLOGY REQUEST

ICD-CM DIAGNOSIS CODE(S): REQUIRED

SPECIMEN SOURCE:

☐ CERVICAL ☐ ENDOCERVICAL ☐ VAGINAL
☐ THINPREP PAP ☐ CONVENTIONAL PAP
☐ REFLEX HPV IF ASC/LSIL (HR + 16/18 GENOTYPE)
☐ REFLEX HPV IF ASC (HR + 16/18 GENOTYPE)
☐ THINPREP PAP AND HPV-HR CO-TESTING (RECOMMENDED FOR WOMEN OVER 30 YEARS)

ADDITIONAL TESTING FROM THINPREP (REQUIRES ICD CODE)

☐ CHLAMYDIA _____ (ICD) ☐ NO PAP
☐ GC _____ (ICD)
☐ HERPES SIMPLEX VIRUS I & II _____ (ICD)
☐ HPV HR + 16/18 GENOTYPE (NO PAP) _____ (ICD)

CLINICAL HISTORY: LMP (REQUIRED): _____

☐ PREGNANT _____ WKS.
☐ POST PARTUM ☐ ABN. BLEEDING
☐ TOTAL OR ☐ SUPRACERVICAL HYSTERECTOMY
☐ POST MENOPAUSAL ☐ BCP ☐ IUD ☐ HRT
☐ CONIZATION ☐ CRYOTHERAPY ☐ LEEP
☐ CHEMOTHERAPY ☐ RADIATION ☐ PREV. DYSPLASIA

NON-GYN CYTOLOGY REQUEST

SPECIMEN SOURCE:

☐ BRONCHIAL BRUSHING SITE ____ RT ____ LT
☐ BRONCHIAL WASHING SITE ____ RT ____ LT
☐ BRONCHOALVEOLAR LAVAGE
☐ SPUTUM ☐ PNEUMOCYSTIS SCREEN
☐ NIPPLE DISCHARGE ____ RT ____ LT
☐ FINE NEEDLE ASPIRATION
SITE: _____ ☐ CYST ☐ SOLID MASS

☐ URINE ____ CATH. ____ VOID
☐ BLADDER WASHING
☐ PERITONEAL FLUID
☐ SPINAL FLUID
☐ PLEURAL FLUID

CLINICAL HISTORY:

☐ COPD
☐ MASS
☐ PNEUMONIA
☐ HEMOPTYSIS
☐ SOB
☐ HEMATURIA
CANCER HISTORY SITE: _____

SURGICAL PATHOLOGY REQUEST

CLINICAL DIAGNOSIS (REQUIRED):

OPERATION:

TISSUE SUBMITTED

DID YOU REMEMBER . . . .
TO INCLUDE DIAGNOSIS CODE(S)? TO REQUEST OR MARK TEST(S)?

SIGNATURE OF PERSON COMPLETING THIS FORM:

WHITE COPY: HIGHLANDS PATHOLOGY CONSULTANTS

YELLOW COPY: CLIENT