Highlands Pathology Consultants, P.C.

www.highlandspath.com
2175 Hwy. 75, Suite 4, Blountville, TN 37617
Billing: 423-323-5290 Bristol 423-844-3220 Kingsport 423-224-6711

ORDERING PHYSICIAN-LAST NAME, FIRST

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

PATIENT'S STREET ADDRESS | CITY, STATE, ZIP

PHONE # | DATE OF BIRTH / / | SEX M F | PATIENT'S MRN | S.S. NUMBER

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

ADDITIONAL REPORT COPIES

TO: _____

FAX REPORT TO:

ATTN: _____

FAX NO.

COLLECTION DATE/TIME _____ AM PM PATIENT LOCATION ___OFFICE ___ SAME DAY SERVICES ___OTHER_____

GYN CYTOLOGY REQUEST

ICD-10 DIAGNOSIS CODES
REASON FOR TESTING

R E Q U I R E D

CLINICAL HISTORY: LMP_____/_____/_____
LAST NORMAL PAP DATE _____/_____/_____
LAST HPV TEST DATE _____/_____/_____
PREVIOUS ABNORMAL PAP/HPV _____/_____/_____
RESULTS OF ABNORMAL PAP/HPV _____
PREVIOUS BIOPSY DATE _____/_____/_____
PREVIOUS BIOPSY RESULTS _____

CHECK ALL THAT APPLY

- ☐ ABN BLEEDING
- ☐ ABN DISCHARGE
- ☐ CONTRACEPTIVE
- ☐ DES EXPOSURE
- ☐ HRT
- ☐ IUD
- ☐ POST MENOPAUSAL
- ☐ POST PARTUM
- ☐ PREGNANT ___ WEEKS
- ☐ PREVIOUS DYSPLASIA
- ☐ PREVIOUS UNSAT PAP
- ☐ VISIBLE LESION/MASS

PREVIOUS PROCEDURES: CHECK ALL THAT APPLY

- ☐ CHEMOTHERAPY
- ☐ COLPOSCOPY
- ☐ CONIZATION
- ☐ CRYOTHERAPY
- ☐ LEEP
- ☐ PARTIAL HYSTERECTOMY
- ☐ TOTAL HYSTERECTOMY
- ☐ RADIATION

SPECIMEN SOURCE: ☐ **CERVICAL/ENDOCERVICAL** ☐ **VAGINAL**

An ABN (Advanced Beneficiary Notice of Noncoverage) form must be completed for ALL TRADITIONAL MEDICARE PATIENTS and sent with their specimen.

DIAGNOSTIC SECTION ONLY **INCLUDE ICD-10 (REQUIRED) PER TEST**

THERE HAVE BEEN PREVIOUS ABNORMALS, SIGNS OR SYMPTOMS OF DISEASE, AT HIGHER RISK FOR STI, HAD DES EXPOSURE, OR IS IMMUNOCOMPROMISED

☐ THIN PREP PAP (IMAGED) ☐ HPV (INCLUDES 16/18GT) ☐ CHLAMYDIA ☐ N. GONORRHOEAE (NG)

MEDICARE AND MOST COMMERCIAL INSURANCE WILL NOT COVER HPV FOR ANYONE 66 AND OLDER

SCREENING SECTION ONLY **INCLUDE ICD-10 (REQUIRED) PER TEST**

NO SIGNS OR SYMPTOMS OF DISEASE, STRICTLY PREVENTIVE IN NATURE. SCREENING THINPREP PAPS ARE IMAGED.
AGE BASED SCREENING (AGES 21-65) BASED ON ACOG, ASCCP, AND/OR USPSTF RECOMMENDED SCREENING GUIDELINES

☐ **WOMEN AGES 21-24** THINPREP PAP AND CT/NG (CT/NG RECOMMENDED YEARLY)
☐ **WOMEN AGES 21-24** THINPREP PAP ALONE
☐ **WOMEN AGES 25-29** AT HIGHER RISK FOR STI: THINPREP PAP & CT/NG
☐ THINPREP PAP ALONE OR ☐ PRIMARY HPV SCREENING WITH 16/18GT

ADDITIONAL TESTS: ☐ REFLEX HPV IS ASC (INCLUDES 16/18GT) ☐ REFLEX HPV IF ASC/LSIL (INCLUDES 16/18GT) ☐ REFLEX TO PAP IF PRIMARY HPV IS POS

☐ **WOMEN AGES 30-65: CHOOSE AN OPTION BELOW**
☐ THINPREP PAP AND HPV COTEST WITH CT/NG (IF AT HIGHER RISK FOR STI)
☐ THINPREP PAP AND HPV COTEST ☐ PRIMARY HPV SCREEN WITH 16/18 GT OPTIONAL ☐ REFLEX TO THINPREP PAP IF PRIMARY HPV IS POSITIVE
☐ THINPREP PAP ALONE NOTE: WOMEN 66 AND ABOVE: Pap may be performed, but Medicare and Commercial Insurance WILL NOT COVER HPV tests.
ADDITIONAL TESTS: ☐ REFLEX HPV IF ASC (INCLUDES 16/18GT) ☐ REFLEX HPV IF ASC/LSIL (INCLUDES 16/18GT) ☐ REFLEX TO PAP IF PRIMARY HPV IS POS

NOTE: WOMEN 30-65: PAP and HPV COTESTING IS AN OPTION FOR Medicare patients annually with a completed ABN (for traditional Medicare) OR if the PAP has been at least 2 years and the HPV has been at least 5 years. Most Commercial Insurance will cover COTESTING if the pap has been at least 3 years and the HPV has been at least 5 years.

GYN ANCILLARY TESTS **INCLUDE ICD-10 (REQUIRED) PER TEST**

☐ **CHLAMYDIA** ☐ **N. GONORRHOEAE (NG)** ☐ **HERPES SIMPLEX VIRUS 1 AND 2 mRNA**

NON-GYN CYTOLOGY REQUEST

CLINICAL DIAGNOSIS (ICD-10 REQUIRED) _____

CLINICAL HISTORY ☐ CANCER HISTORY (SITE) _____
☐ COPD ☐ HEMATURIA ☐ HEMOPTYSIS ☐ MASS ☐ SOB ☐ PNEUMONIA

SPECIMEN SOURCE:
☐ ANAL CYTOLOGY ☐ ANAL HPV (NOTE: ANAL HPV IS SENT TO REFERENCE LAB)
☐ BLADDER WASH ☐ URINE (_____CATH OR _____VOIDED)
☐ BRONCHIAL BRUSHING ☐ R ☐ L ☐ BRONCHIAL WASHING ☐ R ☐ L
☐ BRONCHOALVEOLAR LAVAGE ☐ R ☐ L ☐ COMBINED
☐ ESOPHAGEAL/GASTRIC BRUSHING ☐ JOINT/SYNOVIAL FLUID (SITE): _____
☐ FINE NEEDLE ASPIRATE ☐ CYST ☐ SOLID MASS (SITE): _____
☐ GMS STAIN FOR FUNGAL ORGANISMS INCLUDING PNEUMOCYSTIS
☐ NIPPLE DISCHARGE ☐ R ☐ L ☐ PELVIC WASH ☐ PLEURAL FLUID
☐ SPINAL FLUID ☐ SPUTUM

SURGICAL PATHOLOGY REQUEST

CLINICAL DIAGNOSIS (ICD-10 REQUIRED) _____

TISSUE SUBMITTED:

PROCEDURE:

SIGNATURE OF PERSON COMPLETING THIS FORM:

WHITE COPY: HIGHLANDS PATHOLOGY CONSULTANTS **YELLOW COPY: CLIENT**