

812 HURON ROAD, SUITE 520, CLEVELAND, OHIO 44115 PHONE: (800) 527-6446 • FAX (216) 861-1720

ACCOUNT INFORMATION

ACCOUNT NO. _____ TELEPHONE NO. _____

ACCOUNT NAME AND ADDRESS _____

REQUESTING PHYSICIAN / REFERRING PHYSICIAN _____

PATIENT INFORMATION

PATIENT SOC. SEC. NO. _____ Sex _____ DATE OF BIRTH _____

PATIENT LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

MEDICAL RECORD NO. _____ PATIENT TELEPHONE NO. _____

BILLING INFORMATION

BILL TO MEDICARE: _____

BILL TO MEDICAID: # _____

EFFECTIVE DATE: ____/____/____ STATE: _____

BILL TO MANAGED CARE PLAN

BILL TO PATIENT (Address Given)

BILL TO ACCOUNT

REFERRAL NO. _____

INSURANCE/MANAGED CARE PLAN _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

POLICY NO. _____ GROUP NO. _____

IF GROUP, NAME OF EMPLOYER _____

INSURED OR RESPONSIBLE PARTY, IF OTHER THAN PATIENT _____

LAST NAME _____ FIRST NAME _____

INSURED SOCIAL SECURITY NUMBER _____

PT RELATIONSHIP TO INSURED: SPOUSE CHILD OTHER

PLEASE ATTACH ADDITIONAL SECONDARY INSURANCE INFORMATION

PATIENT AUTHORIZATION

PATIENT AUTHORIZATION:
I authorize any holder of medical or other information about me to release to the Social Security administration, its intermediaries, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

PATIENT SIGNATURE _____ DATE _____

DIAGNOSIS ICD-9 CODE: _____

TEST REQUESTED - LIQUID BASED PAP

Date of Collection: ____/____/____ Date Received: ____/____/____

Specimen Source: VCE VAGINAL CERVICAL ECTO/ENDOCERVICAL
 Liquid Based Pap

<input type="checkbox"/> Dual Screening (PAP & HPV) Or <input type="checkbox"/> Reflex Screening (Pap w/ ASC-US & HPV) <i>Method Option MUST be selected if HPV is requested. If no choice is selected PCR will be the default method.</i>	HPV Method Options <input type="checkbox"/> PCR Or <input type="checkbox"/> Digene Hybrid Capture	<input type="checkbox"/> Gonorrhea & Chlamydia Or <input type="checkbox"/> Gonorrhea Or <input type="checkbox"/> Chlamydia
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CLINICAL SYMPTOMS AND STATUS

LMP ____/____/____ Hysterectomy Postmenopause DUB

Postpartum Vaginal Discharge Oral Contraceptives IUD

Postmenopausal Bleeding Pregnant, Duration _____ wks Other _____

HORMONAL/THERAPY: Estrogen Progesterone Megace

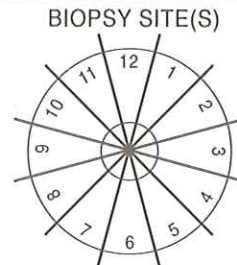
Cervical/Vaginal Cancer: High Risk Low Risk

TEST REQUESTED - BIOPSY AND SITE

Date of Collection: ____/____/____

Date Received: ____/____/____

- | | |
|--|---|
| <input type="checkbox"/> Endometrial Curretting | <input type="checkbox"/> Labia Bx. |
| <input type="checkbox"/> Endocervical Curretting | <input type="checkbox"/> Perineum Bx. |
| <input type="checkbox"/> Endometrial Bx. | <input type="checkbox"/> LEEP: Ant. Post. |
| <input type="checkbox"/> Cervical Bx. | <input type="checkbox"/> Cervical Cone |
| <input type="checkbox"/> Vaginal Bx. | <input type="checkbox"/> FNA Bx Site: _____ |
| <input type="checkbox"/> Vulva Bx. | <input type="checkbox"/> Other _____ |



PREVIOUS PATHOLOGY DIAGNOSIS

Date of Dx ____/____/____ OncoDiagnostic # _____

<input type="checkbox"/> Biopsy	<input type="checkbox"/> WNL	<input type="checkbox"/> ASCUS	<input type="checkbox"/> HPV Effect	<input type="checkbox"/> Invasive CA
<input type="checkbox"/> Pap Smear	<input type="checkbox"/> LGSIL (CIN 1)	<input type="checkbox"/> Squamous CA	<input type="checkbox"/> Adeno CA	
	<input type="checkbox"/> HGSIL (CIN 2,3 CIS)	Other _____		

PREVIOUS TREATMENT

Treatment Date: ____/____/____ Cervical Conization Hysterectomy

LEEP Radiation Cryosurgery Laser Surgery

Other _____

COLPOSCOPIC FINDINGS & DIAGNOSIS

TRANSFORMATION ZONE: FULLY VISUALIZED NOT FULLY VISUALIZED UNSATISFACTORY

<input type="checkbox"/> ACETOWHITE EPITH.	<input type="checkbox"/> PUNCTATION	<input type="checkbox"/> ATYPICAL VESSELS
<input type="checkbox"/> IODINE NEG EPITH.	<input type="checkbox"/> MOSAIC	<input type="checkbox"/> LEUKOPLAKIA
<input type="checkbox"/> NON-ACETOWHITE EPITH.	<input type="checkbox"/> EROSIONS	<input type="checkbox"/> ULCER
<input type="checkbox"/> EXOPHYTIC CONDYLOMA		<input type="checkbox"/> INFLAMMATION

OTHER _____

PROGNOSTIC MARKERS (REQUIRES SIGNED ABN)

DNA Ploidy p53 Ki-67 EGFR p16
 Estrogen Receptor Progesterone Receptor MCM-5 OTHER

ORDER KITS

How many Pap kits? ____ How many Biopsy kits? ____ How many Endometrial kits? ____