

1-173783

HCRF-B

PROFESSIONAL SOLUTIONS USA, INC. • (336) 570-3813

DATE SUBMITTED		REQUESTING PHYSICIAN		LAST / FIRST :	
COPIES TO: (include initials)		LAST / FIRST :		FAX NUMBER	
PATIENT INFORMATION: Please Print					
PATIENT NAME: LAST		FIRST		MIDDLE	
PATIENT MAILING ADDRESS					
CITY		STATE		ZIP	
TELEPHONE NO.		DATE OF BIRTH	SEX	RACE	S.S. NO.
PARENT NAME IF PATIENT UNDER 18				CHART NO.	

PATHOLOGISTS DIAGNOSTIC LABORATORY, PA
 630 Brookwood Business Park Dr.
 Winston Salem, NC 27105
 www.pdspath.com

HISTOLOGY / CYTOLOGY REQUEST FORM
 (336) 306-5777
 Fax (336) 602-2609

Client Location & Phone Number

Lab accessn by

INSURANCE - COMPLETE OR ATTACH COPIES OF CARD(S)	
PRIMARY <input type="checkbox"/> SECONDARY <input checked="" type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID NC/VA/WVA <input type="checkbox"/> BCBS-NC <input type="checkbox"/> BLUE MEDICARE <input type="checkbox"/> CIGNA <input type="checkbox"/> MEDCOST <input type="checkbox"/> UNITED <input type="checkbox"/> SELF PAY <input type="checkbox"/> OTHER <input type="checkbox"/> OTHER <input type="checkbox"/>	PRIMARY SUBSCRIBER NAME: _____ SUBSCRIBER ID: _____ GROUP #: _____ INSURANCE CO. ADDRESS: _____ SUBSCRIBER'S EMPLOYER: _____
SECONDARY SUBSCRIBER NAME: _____ SUBSCRIBER ID: _____ GROUP #: _____ INSURANCE CO. ADDRESS: _____ SUBSCRIBER'S EMPLOYER: _____	

CLINICAL HISTORY / EXAM / DIAGNOSIS / ICD CODE

PREVIOUS PATHOLOGY? # _____

PAP SMEAR

Source: Cervix/Endocx or Vagina

Select ONE from the following:

Non-Medicare Routine Screening Pap

Diagnostic Pap

(Reason) _____

Medicare Screening Pap

If so, Low risk or High risk

WRITE COMPLETE NAME ON LABEL AND PLACE ON SPECIMEN.

SITE / ADDITIONAL CLINICAL Circle relevant items, add any other information

1	HISTOLOGY- BIOPSY EXCISION	VOIDED	Left
	CYTOLOGY- FNA URINE Catheter PI. Effusion Right CSF		
2	HISTOLOGY- BIOPSY EXCISION	VOIDED	Wash
	CYTOLOGY- FNA URINE Catheter RESPIR Brush CSF		
3	FLOW CYTOMETRY- BIOPSY of (site) MARROW Core BLOOD OTHER	FNA of _____	Aspirate
	HISTOLOGY- BIOPSY EXCISION		
4	HISTOLOGY- BIOPSY EXCISION		

Required Clinical Information:

LMP: _____ or Postmenopausal

Previous abnormal Pap _____

Previous abnormal biopsy _____

Pregnant Discharge

Postpartum Abnormal exam

Radiation/Chemo Immunosuppressed

Hysterectomy Abnormal bleeding

Contraceptive/hormone maintenance

Ancillary Testing:

HPV test HIGH risk ONLY (if ASCUS)

HPV test Regardless

Chlamydia/Gonorrhea

For more specimens on this patient, staple additional HISTOLOGY / CYTOLOGY form to this one, complete name & birthdate sections

Check if URGENT

If Urgent phone / page to _____

PATHOLOGY USE ONLY			
88302		Cytopathology	Molecular - Flow & morphometry
88304		88112	-TC 88184 (up to 1)
88305		88104	& 88185 (rest)
88307		88141	-PC 88187 (x1 for 2-8)
Decal and Stains		10021	or 88188 (x1 for 9-15)
88311		88172	or 88189 (x1 for 16+)
88312		88173	88360 (manual)
88313		Frozen sections	88361 (C-vis)
88342		88331	Outside
		88332	88321
			88323