



TULSA MEDICAL LABORATORY, LLC

6565 South Yale, Ste 410, Tulsa, OK 74136
PH: 918-481-7850

DATE ____/____/____

LAST FIRST MIDDLE INITIAL DATE OF BIRTH

_____/____/____

ADDRESS HOME PHONE

CITY STATE ZIP CODE

SSN AND/OR MRN M F

_____ SEX M F

PHYSICIANS(S) CLINIC OR HOSPITAL

TYPE OF BILLING REQUESTED

BILL TO: (PLEASE INDICATE)

- PATIENT INSURANCE PHYSICIAN/CLINIC
- MEDICARE HIC NUMBER MEDICAID CASE NUMBER

(MEDICARE BENEFICIARY SIGNATURE ON FILE AT PHYSICIAN'S OFFICE)

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY/HEALTH NETWORK:

CLAIMS MAILING ADDRESS:

NAME OF SUBSCRIBER PT RELATIONSHIP TO SUBSCRIBER

- SELF SPOUSE CHILD

SUBSCRIBER'S EMPLOYER

CERTIFICATE/POLICY NUMBER GROUP NUMBER

TISSUE PATHOLOGY

CLINICAL INFORMATION/HISTORY: _____

PREOP DX: _____

POST OP DX: _____

DIFFERENTIAL DIAGNOSIS: _____

FROZEN SECTION PERFORMED: _____

PREVIOUS ABN SMEAR OR BIOPSY: _____

TIME COLLECTED: _____ TIME IN FORMALIN: _____

SPECIMEN SOURCE (S): _____

SPECIMEN :

A: _____ I: _____

B: _____ J: _____

C: _____ K: _____

D: _____ L: _____

E: _____ M: _____

F: _____ N: _____

G: _____ O: _____

H: _____ P: _____

DATE SPECIMEN OBTAINED ____/____/____

PERTINENT PATIENT HISTORY

(ANATOMIC/CYTOLOGY SPECIMENS)

DIAGNOSIS/ICD CODE(S): _____

CANCER YES NO

(SITE) _____

CHEMOTHERAPY YES NO

RADIATION THERAPY YES NO

PSA: _____

ADDITIONAL COMMENTS: _____

GYNECOLOGIC CYTOLOGY

FOR MEDICARE PATIENTS: SCREENING DIAGNOSTIC

ATTACH ABN FORM

THINPREP- PAP TEST W/IMAGER DNA W/PAP - (age 30-64)

PAP SMEAR- CONVENTIONAL PAP SUBMITTED W/BIOPSY

DIAGNOSTIC RUSH? YES NO

SUPPLEMENTAL TESTS FROM THIN PREP VIAL

HPV ASSAY IF ASC ASC-H LSIL HSIL AGC REGARDLESS OF DIAGNOSIS

DO NOT PERFORM HPV TEST HPV ONLY (NO PAP)

CHLAMYDIA/GONORRHEA CHLAMYDIA/GONORRHEA ONLY (NO PAP)

TRICHOMONAS VAGINALIS TRICHOMONAS VAGINALIS ONLY (NO PAP)

SUPPLEMENTAL TESTS FROM APTIMA TUBES

HERPES BY NAAT (ANOGENITAL LESION ONLY) CANDIDA/TRICHOMONAS VAGINALIS

CHLAMYDIA/GONORRHEA ONLY BACTERIAL VAGINOSIS

TRICHOMONAS VAGINALIS ONLY MYCOPLASMA GENITALIUM

SPECIMEN TYPE: CERVICAL/ENDOCERVICAL CX STUMP

VAG CUFF CVE (CERVICAL VAG. ENDOCX)

VAG WALL (FOR HORMONAL EVAL.) ENDOMET

PT. HX: PRENATAL PREMENOPAUSAL POST-PARTUM

POST-HYST POST-MENOPAUSAL PERI-MENOPAUSAL

LMP ____/____/____

PREV. CYTOLOGY? _____ (DATE) YES NO

HORMONE USAGE? B.C.P.'S P.M. TX

IUD? YES NO IUD W/HORMONES

ABN. CYTOLOGY? _____ (DATE) YES NO

PREV. HPV ASSAY _____ (DATE)

CX LESION? YES NO OTHER _____

ABN BLEEDING? YES NO

NON-GYNECOLOGIC CYTOLOGY

ANAL PAP CEREBROSPINAL FLUID

BRONCHIAL BRUSH SITE _____ PERICARDIAL FLUID

BRONCHIAL WASH SITE _____ PLEURAL FLUID

BRONCHOALVEOLAR LAVAGE PERITONEAL FLUID

SPUTUM PERITONEAL WASH

URINE: VOIDED CATH ILEAL CONDUIT

BLADDER WASH W/UroVysion TESTING

GI TRACT: (SPECIFY SITE) _____

BREAST (nipple discharge) RIGHT LEFT

FNA: SITE _____ RIGHT LEFT

OTHER: _____

LAB USE ONLY: AMT _____ CC UNFIXED FIXED

APPEARANCE: CLEAR CLOUDY MUCOID BLOODY

CLOTTED FOAMY COLOR

ADDITIONAL COMMENTS: _____

If the patient is Medicare, the ordering physician must sign requisition: _____

Physician signature