TULSA MEDICAL LABORATORY, LLC

6565 South Yale, Ste 410, Tulsa, OK 74136
Pathology 918-281-6854 / Cytology 918-281-6864

DATE _____/_____/_____

LAST FIRST MIDDLE INITIAL DATE OF BIRTH

/ /

ADDRESS HOME PHONE

CITY STATE ZIP CODE

SSN AND/OR MRN M F

SEX

PHYSICIANS(S) CLINIC OR HOSPITAL

TYPE OF BILLING REQUESTED

BILLTO: (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 requistion:_____

Physician signature

TML-205 Cytology Requisition Rev 10-26-20