LabCorp INDIANA, INC.
530 North Lafayette Boulevard
South Bend, IN 46601-1098

South Bend Medical Foundation
530 North Lafayette Boulevard
South Bend, IN 46601-1098

CYTOLOGY REQUISITION

J.L. Simpson MD
Medical Director

Client Code: ( ) **Name:** _____

✓	Dr #	Physician's Last Name, First Name	✓	Dr #	Physician's Last Name, First Name
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		

Signature of Ordering Provider

_____

(Signature must be dated, legible, and include first and last name)

Date_____

PATIENT INFORMATION – Please PRINT or place label here

Name _____
Last First MI

SS#_____

DOB_____ SEX _____
MO / DAY / YEAR

SPECIMEN COLLECTION

Date: _____ Collector's
MO / DAY / YEAR Initials:___

Time: _____ ☐ AM ☐ PM

Fasting? ☐ Yes ☐ No

BILLING

☐ PHYSICIAN / ACCOUNT
☐ PATIENT / INSURANCE
(SEE REVERSE)
☐ BCCP, Alpha ID# _____
IF NO BILLING INFORMATION IS PROVIDED, AND NO BOX IS CHECKED YOUR ACCOUNT WILL BE BILLED.

REMINDER: Tests noted with an **asterisk (*)** and in **BOLD** print may require patient signature on advance beneficiary notice (ABN) Refer to SBMF Medical Necessity Guide Book.

PRIORITY ☐ **Routine** ☐ **Phone**
☐ **STAT** ☐ **Fax#** _____

Performing Radiologist: _____
Ordering Physician: _____

Copy To: _____
Copy To: _____

GYNECOLOGIC CYTOPATHOLOGY

Collection Date _____ / _____ / _____
Last Menstrual Period **(REQUIRED)** _____ / _____ / _____

SOURCE REQUIRED
☐ Cervical, Endocervical
☐ Vaginal ☐ Other _____

☐ Pregnant
# of weeks_____
☐ IUD _____
☐ Postmenopausal
☐ Hysterectomy:
☐ Supra cervical or ☐ Total

CLINICAL HISTORY REQUIRED
☐ Postpartum
☐ Abnormal Bleeding
☐ High Risk Patient
☐ Hormonal Therapy

PREVIOUS ABNORMAL HISTORY REQUIRED
Date _____ / _____ / _____
RESULTS: ☐ ASC-US ☐ LSIL ☐ HSIL ☐ Carcinoma
High Risk HPV? ☐ Yes ☐ No
Treatment: _____

SCREENING PAP • ✓ Test PLUS – Diagnosis or DIAGNOSTIC PAP • ✓ Test PLUS – Diagnosis

☐ **24250** **Thin Prep Screen Pap***

☐ **24254** **Screen Pap and HPV DNA* High risk recommended for women over age 30 depending on history**

☐ **24251** **Screen Pap and HPV DNA* High Risk –if ASC-US (age 21 and over)**

☐ **24253** **Screen Pap and HPV DNA High Risk* –If ASC-US or LSIL, recommended for post-menopausal women**

DIAGNOSIS: _____

☐ **24100** **Sure Path Screen Pap***

☐ **24208** **Sure Path + HPV***

☐ **24216** **Sure Path + HPV if ASC***

☐ **24206** **Sure Path + HPV if A/LSIL***

☐ **24350** **Thin Prep Diagnostic Pap***

☐ **24354** **Diagnostic Pap and HPV DNA *High Risk**

☐ **24351** **Diagnostic Pap and HPV DNA *High Risk if ASC-US**

☐ **24353** **Diagnostic Pap and HPV DNA *High Risk if ASC-US or LSIL**

DIAGNOSIS:_____

☐ **24200** **Sure Path Diag. Pap***

☐ **24204** **SPDX+HPV***

☐ **24212** **SPDX+HPV if ASC***

☐ **24202** **SPDX+ if A/L***

HPV, CHLAMYDIA / GC TESTING FROM PAP VIAL

☐ **36391**	**HPV-TP, High Risk HPV, ThinPrep Vial***	☐ **36392**	**HPV-SP, High Risk HPV, SurePath Vial***
☐ **36370**	**Thin Prep Chlamydia trachomatis & Neisseria gonorrhoeae by Nucleic Acid Amplification***	☐ **36380**	**SUREPATH Chlamydia trachomatis & Neisseria gonorrhoeae by Nucleic Acid Amplification***
☐ **36371**	**Thin Prep Chlamydia trachomatis by Nucleic Acid Amplification***	☐ **36381**	**Chlamydia trachomatis by NAA, SurePath**
☐ **36372**	**Thin Prep Neisseria gonorrhoeae by Nucleic Acid Amplification***	☐ **36382**	**Neisseria gonorrhoeae by NAA, SurePath**

DIAGNOSIS:_____ ***NOTE: Additional Charge for HPV DNA / See Reverse Side for Financial Agreement** **DIAGNOSIS:**_____

NON-GYNECOLOGIC CYTOPATHOLOGY

Fine Needle Aspiration

☐ Breast Lesion _____ ☐L ☐R
☐ Liver _____ ☐L ☐R
☐ Lung _____ ☐L ☐R
☐ Lymph Node _____ ☐L ☐R
Location _____
☐ Salivary Gland_____ ☐L ☐R
(specify) _____
☐ Thyroid _____ ☐L ☐R
☐ Other FNA_____ ☐L ☐R
(specify) _____

Non-Gynecologic- Fluid and Prepared Slides

☐ Breast Discharge ☐L ☐R
☐ Bronchial Brush ☐L ☐R
☐ Bronchial Wash ☐L ☐R
☐ Cerebrospinal Fluid
☐ Peritoneal Fluid ☐L ☐R ☐Bilateral
☐ Pleural Fluid ☐L ☐R ☐Bilateral
☐ Sputum
☐ Urine, Catheterized or Cystoscopy
☐ Urine, UroVysion FISH if Atypical/Suspicious Cytology
☐ Urine, Voided
☐ Other (specify)_____

COLLECTION DATE: _____ / _____ / _____
COLLECTION TIME _____
_____ Smears (Prefer Ethanol Fixed) _____ # Submitted
_____ Fluid _____ Quantity Submitted

NONGYN CLINICAL HISTORY OR RADIOGRAPHICFINDINGS

Please List Signs, Symptoms, and Reason for Collection.

PREPARATION GUIDELINES

- DO NOT USE ThinPrep Vials with Non-Gyn Specimens
- Label All Smears and Specimen Containers with Patient Name
  FIXATION
- Prepared smears – immediate fixation in 95% Ethanol
- Fluid and remaining FNA specimens – 30 ml in cytology fixative
- Large volume specimens (>30 ml) – submit 30 ml in cytology fixative and remainder in the original container.

FOR LABORATORY USE ONLY

_____ Collected _____ total
_____ Received _____ slides
_____ Fixed _____ Unfixed
Wash _____ yes _____ no
tissue _____ yes _____ no
Received # _____ CC Color _____ Fluid: ☐Fixed ☐Unfixed

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For our locations and hours
Please visit our website @
www.sbmf.org or call us at
574-234-4176 and press 5
800-544-0925 and press 5

INSURANCE INFORMATION

Responsible Party Name (Required if patient is a minor):

Responsible Party Address:

City | State | Zip

Responsible Party Phone

( ) _____ - _____

☐ Medicare # _____

☐ Medicaid # _____ EDD _____ MM/DD/YY

☐ Primary Insurance (Complete or attach copy of insurance card.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

☐ Secondary Insurance (Complete or attach copy of insurance card front & back.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

IMPORTANT
A WRITTEN ORDER AND AN APPROPRIATE DIAGNOSIS MUST ACCOMPANY EACH LABORATORY TEST. WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, ONLY TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT SHOULD BE ORDERED.

MICROBIOLOGY PROTOCOL
MICROBIOLOGY CULTURES MAY INCLUDE CHARGES FOR ONE PRIMARY SOURCE SMEAR, ONE PRIMARY CULTURE, ONE CHARGE PER ORGANISM REQUIRING IDENTIFICATION, AND ONE CHARGE PER SENSITIVITY PERFORMED. This is source specific. Refer to the fee schedule for further clarification, or call Labcorp Indiana, Inc Client Services Department at (574) 236–7263 or (800) 950-7263

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

EVERY patient MUST read, sign, and date:

I request that payment of authorized Medicare or insurance benefits be made on my behalf to the LabCorp Indiana, Inc.

I authorize any holder of medical or other information about me that pertains to the determination of payable benefits for related services to release such information to my designated insurance company and/or Centers of Medicare and Medicaid Services (CMS) and their agents.

I agree that I am fully responsible for the payment of all the designated laboratory services LabCorp Indiana, Inc. rendered to me or on my behalf. I accept responsibility for charges Medicaid does not cover when I am enrolled in a limited coverage Medicaid program.

I understand that additional testing may be performed based on my physician's request. I agree to be fully responsible for payment if my insurance plan does not cover the cost.

I also agree that if any insurance plan, except Medicaid, determines the test(s) requested to be medically unnecessary, and/or uncovered procedure(s), and denies payment to LabCorp Indiana, Inc., I accept full responsibility for payment to LabCorp Indiana, Inc.

_____ Patient Signature

_____ Date