NON-GYNECOLOGIC CYTOPATHOLOGY REQUISITION

J.L. Simpson MD, Medical Director

530 North Lafayette Boulevard
South Bend, IN 46601-1098

Client Code: ( ) Name: ______________________

✓	Dr #	Physician's Last Name, First Name	✓	Dr #	Physician's Last Name, First Name
[ ]		______________	[ ]		______________
[ ]		______________	[ ]		______________
[ ]		______________	[ ]		______________
[ ]		______________	[ ]		______________
[ ]		______________	[ ]		______________
[ ]		______________	[ ]		______________
[ ]		______________	[ ]		______________
[ ]		______________	[ ]		______________

Signature of Ordering Provider and Date

____

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

Printed Name ______________________________

PATIENT INFORMATION – Please PRINT or place label here

Name ______________________________
Last First MI

SS# ______________________________

DOB ______________ SEX ______________
MO / DAY / YEAR

BILLING – PLEASE INCLUDE FACESHEET
IF NO BILLING INFORMATION IS PROVIDED YOUR ACCOUNT WILL BE BILLED.

☐ PRIOR AUTHORIZATION
☐ PHYSICIAN / ACCOUNT
☐ PATIENT/INSURANCE - (SEE REVERSE)
☐ BCCP, Alpha ID# ______________

SBMF USE ONLY
Accession #/Label

SPECIMEN COLLECTION

Date and Time ______________________ ☐ AM ☐ PM

Collector's Initials: ______________

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

Performing Radiologist/Physician: ______________________

Ordering Physician: ______________________

Copy To: ______________________

Copy To: ______________________

38560: NON-GYNECOLOGIC CYTOPATHOLOGY

Fine Needle Aspiration

See PREPARATION GUIDELINES Below

- ☐ Breast Lesion ☐**L** ☐**R**
- ☐ Liver
- ☐ Lymph Node
  Location ______________
- ☐ Lung ☐**L** ☐**R**
- ☐ Salivary Gland ☐**L** ☐**R**
  Specify______________
- ☐ Thyroid* #1 ______________ ☐**L** ☐**R**
- ☐ Thyroid* #2 ______________ ☐**L** ☐**R**
- ☐ **EUS**
  Location ______________
- ☐ Other FNA ☐**L** ☐**R**
  Specify______________

Fluids

- ☐ Breast Discharge
- ☐ Cerebrospinal Fluid
- ☐ Peritoneal Fluid
- ☐ Pelvic Wash
- ☐ Pleural Fluid
  Source: ☐**L** ☐**R** ☐**Bilateral**
- ☐ Urine
  Source: ☐**Cath/Cysto** ☐**Voided**
- ☐ Other
  Specify______________

Respiratory

- ☐ Bronchial Brush **L**__________
- ☐ Bronchial Wash ☐ & Pneumocystis **L**__________
- ☐ BAL ☐ & Pneumocystis **L**__________
- ☐ BAL for Lipid (**requires unfixed sample**) **L**__________
- ☐ BAL for Iron **L**__________
- ☐ Navigational Bronchoscopy
  Location ______________
- ☐ **EBUS**
  Location ______________
- ☐ Lymph Node #1 ☐**L** ☐**R**
  Location ______________
- ☐ Lymph Node #2 ☐**L** ☐**R**
  Location ______________
- ☐ Lymph Node #3 ☐**L** ☐**R**
  Location ______________
- ☐ Sputum

PREPARATION GUIDELINES

- Fixation
  - Prepared smears – immediate fixation in 95% Ethanol
  - Fluid and FNA needle rinse/residue – 30 ml in cytology fixative
- Large volume specimens (>30 ml) – submit 30 ml in cytology fixative and the remainder in the original container
- Use Cytolyt fixative only for Non-Gyn Specimens
- Label All Smears and Specimen Containers with Patient Name, DOB and Source.

* For thyroid samples, a limit of **4 smears** is recommended with additional samples submitted in 30 ml cytology fixative.

MATERIAL SUBMITTED

☐ Smears (**prefer ethanol fixed**)
_______ # fixed _______ # air –dried

☐ Fluid ___________ quantity submitted
☐ Clot in Formalin

CLINICAL HISTORY REQUIRED

Please specify patient history and clinical/radiological finding.

FOR LABORATORY USE ONLY

______________ Collected total

______________ Received slides

☐ Fixed ☐ Unfixed

Wash ☐ yes ☐ no

Tissue ☐ yes ☐ no

Received # ____________ CC Color __________

Fluid: ☐ Fixed ☐ Unfixed

South Bend Medical Foundation

For our locations and hours please visit our website @ www.sbmf.org

INSURANCE INFORMATION

Responsible Party Name (required if patient is a minor): ______________________________

Responsible Party Address: ______________________________

City ____________ State ____________ Zip ____________

Responsible Party Phone

( ) ______ - ____________

☐ Medicare # ______________________

☐ Medicaid # ______________________ EDD ____________

M/D/Y ____________

☐ 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 #:	EDI #
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 #:	EDI #
EMPLOYER:	EFFECTIVE DATE:	

IMPORTANT

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

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 South Bend Medical Foundation.

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

I agree that I am fully responsible for the payment of all the designated laboratory services South Bend Medical Foundation 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 tests requested to be medically unnecessary, and/or uncovered procedures, and denies payment to the South Bend Medical Foundation, I accept full responsibility for payment to South Bend Medical Foundation.

______________________________ Patient Signature

____________ Date