

# LAB OUTREACH

Bill Patient     Bill Insurance     Bill Account



Physician signature: \_\_\_\_\_

[piedmont.org/athens](http://piedmont.org/athens)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  M  F    SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Plan#: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Spouse: \_\_\_\_\_

## GYNECOLOGIC CYTOLOGY

COLLECTION DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

### GYN Required Information

Date of LMP: \_\_\_\_\_

ICD Code: \_\_\_\_\_

- Pregnant
- Post Partum
- Hormone Replacement Therapy
- Hysterectomy
- Hysterectomy-Supracervical
- Post Menopausal
- LMP / Menopause Unknown

### Specimen

- Thin Prep Imaging
- Thin Prep Imaging and HPV
- Thin Prep Imaging and HPV w/Reflex to 16,18
- Thin Prep Imaging w/Reflex to HPV, if ASCUS
- Thin Prep Imaging w/Reflex to HPV, if Abnormal
- HPV High Risk Only
- Chlamydia/GC/Trich. Amplified Probe
- Trichomonas

### Frequency

- Non-Medicare Routine Screening PAP (88175)
- Medicare Low Risk Screening PAP  
*(Medicare pays every 2 Years) (G0145)*
- Medicare High Risk Screening PAP  
*(Meets Medicare Standards for more frequent screening than every two years) (88175)*

Diagnostic PAP:

ICD Code: \_\_\_\_\_

*History of abnormality/signs of medical necessity  
(Must include ICD)*

### GYN Source

- Cervix
- Endo-Cervix
- Vagina

## NON-GYN CYTOLOGY

COLLECTION DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

### ICD CODE/Diagnosis/Clinical History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Specimen/Source

- Sputum
- Bronchial Washing    R    L
- Bronchial Brushing    R    L
- Voided Urine
- Catheterized Urine
- Bladder Washing
- Pleural Fluid
- Pericardial Fluid
- Peritoneal Fluid
- CSF
- Fine Needle Aspiration

Source: \_\_\_\_\_

- Breast Nipple Discharge    R    L
- Breast Cyst Discharge    R    L
- Ovarian Cyst    R    L
- Other: \_\_\_\_\_

## HISTOLOGY

COLLECTION DATE: \_\_\_\_\_

TIME IN FORMALIN: \_\_\_\_\_

### ICD CODE/Diagnosis/Clinical History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Frozen Selection
- Tissue Examination

Number of Containers Submitted: \_\_\_\_\_

### Specimen/Source

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**PATIENT LABEL**