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 RICHLAND (509) 392-5920/(833) 369-7268
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LAB NUMBER

CHART #/MRN	DATE OF COLLECTION	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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PATIENT'S NAME (Last Name, First Name, Middle Initial)

ADDRESS

CITY STATE ZIP PHONE

PATIENT SOCIAL SECURITY #	PATIENT BIRTHDATE	COPY TO:
<input type="text"/>	<input type="text"/>	First Name Last Name Location/Phone

INSURANCE DETAILS (Attach Front/Back Copy of Insurance Card) If patient is a minor, provide copy of a parent's insurance card

INSURANCE NAME: POLICY/SUBSCRIBER ID #: VA AUTHORIZATION #

CLAIMS ADDRESS: GROUP #:

NO INSURANCE, BILL PATIENT
 CLINIC DIRECT BILL

REQUIRED BREAST SPECIMEN INFORMATION				ICD-10 CODE(S) REQUIRED	
DATE OF COLLECTION	TIME	BREAST TISSUE REMOVED	TIME	PLEASE INDICATE DIAGNOSIS CODE(S) RELATING TO THE CURRENT PROCEDURE	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

TISSUE/BIOPSY

A _____

B _____

C _____

D _____

E _____

Pre-/Postoperative Diagnosis & Clinical History

LAB USE

P	BLOODY	Y	N
A	BRUSH	Y	N
P			

PAP TESTING

<input type="checkbox"/> Pap Test - Cervix/Endocervix	LMP Date	Last Pap Date	Last Pap Results	Patient History
<input type="checkbox"/> Pap Test - Vagina			<input type="checkbox"/> Negative <input type="checkbox"/> ASCUS	
<input type="checkbox"/> Pap Test - Anus			<input type="checkbox"/> LSIL <input type="checkbox"/> HSIL	

Contraceptive Mgmt Hysterectomy Cervical Stump Menopausal Pregnancy Postpartum Nursing Cervix Grossly Abnormal Hormone Rx

Cryotherapy/Laser Rx Radiation Rx Personal Hx Cancer, Type: _____ High Risk IUD Abnormal Bleeding DES Exposure Conization

HIGH RISK HPV TEST OPTIONS - MARK ALL THAT APPLY	CHLAMYDIA / GONORRHEA / TRICHOMONAS / GBS TEST OPTIONS
<input type="checkbox"/> If Pap result is ASCUS, ASC-H <input type="checkbox"/> REGARDLESS of Pap result <input type="checkbox"/> If Pap result is ASCUS/LGSIL <input type="checkbox"/> Other: _____	Separate ICD-10 Code(s) required <input type="checkbox"/> Reflex HPV 16, 18/45 Genotyping (if High Risk HPV Positive) <input type="checkbox"/> HPV only (no Pap test) <input type="checkbox"/> Chlamydia & Gonorrhea <input type="checkbox"/> Chlamydia only <input type="checkbox"/> Chlamydia/Gonorrhea/Trichomonas <input type="checkbox"/> Trichomonas vaginalis <input type="checkbox"/> Group B Strep by RT-PCR (GBSPCR) <input type="checkbox"/> Antibiotic susceptibility if positive (for Penicillin allergic patient)

VAGINITIS/VAGINOSIS TEST OPTIONS BY REAL-TIME PCR (INCYTE SWAB COLLECTION IS PREFERRED) Separate ICD-10 Code(s) required for Vaginitis/Vaginosis test options

ICD-10 Code(s)	Vaginitis Panel* (VAG-P)	Bacterial Vaginosis Panel* (BVAG-P)	Candida Vaginitis Panel* (CVAG-P)
	<input type="checkbox"/> Candida albicans (CAND-A) <input type="checkbox"/> Gardnerella vaginalis (GARD-V) <input type="checkbox"/> Trichomonas vaginalis (TRICH-V)	<input type="checkbox"/> Atopobium vaginae (ATOP-VAG) <input type="checkbox"/> Gardnerella vaginalis (GARD-V) <input type="checkbox"/> Mobiluncus curtisii (MOB-CUR) <input type="checkbox"/> Mobiluncus mulieris (MOB-MUL) <input type="checkbox"/> Mycoplasma genitalium (MYCO-G) <input type="checkbox"/> Mycoplasma hominis (MYCO-H)	<input type="checkbox"/> Herpes Simplex Virus (HSV1/HSV2) (CYTO-HSV) Lesion(s) swabbed (Universal Transport Medium) <input type="checkbox"/> Ureaplasma species (urealyticum/parvum) (UREA-U) * Panel Includes all tests listed below panel name

NON-PAP CYTOLOGY SPECIMENS

Fine Needle Aspiration, Source: _____ Urine: Voided Instrumented

Respiratory Cytology: Sputum BAL Brushings Washings Location: _____ Pelvic Washings Endocervical Brushings Nipple Discharge (LR)

Effusion Fluid: Pleural (LR) Ascites Location: _____ Other: _____

AFFIX LABEL(S) TO SPECIMEN CONTAINER(S) WITH FULL PATIENT NAME AND SPECIMEN SITE