incyte DIAGNOSTICS

SPOKANE (509) 892-2700/(888) 814-6277
FAX (509) 892-2740
BELLEVUE (425) 646-0922/(877) 288-0922
FAX (425) 646-0925
RICHLAND (509) 392-5920/(833) 369-7268
FAX (509) 866-5020

LAB NUMBER

CHART #/MRN | **DATE OF COLLECTION** | **SEX** ☐ M ☐ F

PATIENT'S NAME (Last Name, First Name, Middle Initial)

ADDRESS

CITY **STATE** **ZIP** **PHONE**

PATIENT SOCIAL SECURITY #

Please write N/A if SSN is unavailable

PATIENT BIRTHDATE

COPY TO:

First Name Last Name Location/Phone

INSURED'S NAME (Attach Copy of Insurance Card)

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Child ☐ Other

POLICY # GROUP # / EMPLOYER

INSURANCE PLAN NAME OR PROGRAM NAME

☐ Bill Office/ Clinic ☐ VA Choice
☐ No Insurance ☐ Group Health ☐ Asuris ☐ Molina ☐ Aetna
☐ Medicare ☐ Regence of WA ☐ Premera ☐ CHPW ☐ Tricare
☐ United Healthcare ☐ Regence of ID ☐ First Choice (Group # Req.) _____
☐ Cigna (Group # Req.) ☐ Blue Cross ☐ Medicaid (State) _____
Other _____

REQUIRED BREAST SPECIMEN INFORMATION

DATE OF COLLECTION | TIME BREAST TISSUE REMOVED | TIME BREAST TISSUE PLACED IN FORMALIN

ICD-10 CODE(S) REQUIRED PLEASE INDICATE DIAGNOSIS CODE(S) RELATING TO THE CURRENT PROCEDURE

TISSUE/BIOPSY

A _____
B _____
C _____
D _____
E _____

Pre-/Postoperative Diagnosis & Clinical History

LAB USE

PAP **BLOODY** Y N **BRUSH** Y N

PAP TESTING

☐ Pap Test - Cervix/Endocervix
☐ Pap Test - Vagina
☐ Pap Test - Anus

LMP Date

Last Pap Date

Last Pap Results
☐ Negative ☐ ASCUS ☐ LSIL ☐ HSIL

Patient History

☐ 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

☐ If Pap result is ASCUS, ASC-H
☐ REGARDLESS of Pap result
☐ If Pap result is ASCUS/LGSIL
☐ Other:_____
☐ Reflex HPV 16, 18/45 Genotyping (if High Risk HPV Positive)
☐ HPV only (no Pap test)

CHLAMYDIA / GONORRHEA / TRICHOMONAS/GBS TEST OPTIONS Separate ICD-10 Code(s) required

ICD-10 Code(s)

☐ Gonorrhea only
☐ Chlamydia only
☐ Trichomonas vaginalis
☐ Group B Strep by RT-PCR (GBSPCR) ☐ Antibiotic susceptibility if positive (for Penicillin allergic patient)
☐ Chlamydia & Gonorrhea
☐ Chlamydia/Gonorrhea/Trichomonas

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)
- ☐ Candida albicans (CAND-A)
- ☐ Gardnerella vaginalis (GARD-V)
- ☐ Trichomonas vaginalis (TRICH-V)

☐ **Bacterial Vaginosis Panel*** (BVAG-P)
- ☐ Atopobium vaginae (ATOP-VAG)
- ☐ Gardnerella vaginalis (GARD-V)
- ☐ Mobiluncus curtisii (MOB-CUR)
- ☐ Mobiluncus mulieris (MOB-MUL)
- ☐ Mycoplasma genitalium (MYCO-G)
- ☐ Mycoplasma hominis (MYCO-H)

☐ **Candida Vaginitis Panel*** (CVAG-P)
- ☐ Candida albicans (CAND-A)
- ☐ Candida glabrata (CAND-G)
- ☐ Candida parapsilosis (CAND-P)
- ☐ Candida tropicalis (CAND-T)

☐ Herpes Simplex Virus (HSV1/HSV2) (CYTO-HSV) Lesion(s) swabbed (Incyte Swab Required)

☐ 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 (☐L☐R)

Effusion Fluid: ☐ Pleural (☐L☐R) ☐ Ascites ☐ Location: _____ ☐ Other: _____

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