Form Instructions | Print | Save | Reset Form

Atrium Health Wake Forest Baptist
Medical Center Boulevard Winston-Salem, NC 27157
(336) 716-2628 (Anatomic Pathology)
(336) 806-9627 (Pathologist On-Call Pager)
(336) 716-7595 (Fax)
http://www.wakehealth.edu/specialty/p/Pathology

Client:	Clinic/Group Name:	
	Address:	
	City, State, ZIP:	
	Fax:	Phone:
	Contact:	Email:

Cytopathology Request Form

This form is for Cytopathology requests only. Form MUST be completed in its entirety (or information attached) in order to provide pathology services. Incomplete information will delay processing.

PATIENT INFORMATION

Name: *Last Name*	*First Name*	*Middle*	*Mother's First Name*	Soc. Sec. Number (*last four digits*):
Marital Status:	Race:	Sex: ☐ Male ☐ Female	Date of birth:	
Address:	City:	State:	ZIP:	
Phone:	Employer:	Employer Phone:		

BILLING AND INSURANCE INFORMATION

Bill To:
Check box(es) & provide details below. Copies of front AND back of insurance card(s) is acceptable substitute.

Primary Insurance: ☐ Medicare ☐ Medicaid ☐ Other *(specify below)*
Secondary Insurance: ☐ Medicare ☐ Medicaid ☐ Other *(specify below)*
☐ **Bill Client**

Complete for all insurers:	**Subscriber Name:**		**Relationship to patient:**
	Policy/ID Number:		
Medicare Information:	Hospital insurance effective date:	Medical insurance effective date:	
	☐ Patient has a signed Advanced Beneficiary Notice (ABN) on file (*required for all routine Medicare Pap tests*)		
Medicaid Information:	Carolina Access Number:	Valid from:	To:
	State issued if NOT North Carolina:		
All other insurance information:	Insurance Company:		Phone:
	Address for Claims:		Plan Number:
	City/State/ZIP:		Effective Date:

PHYSICIAN INFORMATION

Ordering Physician (*please print*):		PCP Name:
Ordering Physician Phone:	Ordering Physician Fax:	PCP Fax:
Ordering Physician Signature:	Date/Time:	☐ Fax copy of report to Primary Care Provider

SPECIMEN INFORMATION

☐ **URGENT, please call results to:** **Attention:**

GYNECOLOGICAL SPECIMEN(S)

****Pap specimens must be collected using liquid-based methods; conventional Pap specimens are not accepted.****

☐ Routine screening ☐ Diagnostic
LMP Date:
☐ Previous Abnormal Pap, year:
Specimen Source: ☐ Cervical ☐ Vaginal ☐ Vulvar
HPV Testing: ☐ NO HPV testing ☐ HPV co-test
☐ HPV reflex test (performed on ASCUS interpretation ONLY)
Clinical presentation (*check all that apply*):
☐ Abnormal bleeding ☐ Pregnant ☐ Post-partum
☐ Post-menopausal ☐ History of chemotherapy/radiation
☐ Prior dysplasia/neoplasia ☐ Hormone therapy
Additional information/comments:

Diagnosis Code/Verbiage:

NON-GYNECOLOGICAL SPECIMEN(S)

Specimen source:
☐ Breast: ☐ Right ☐ Left
☐ Bronchial Wash: ☐ Right ☐ Left
☐ BAL: ☐ Right ☐ Left
☐ Body Cavity Fluid: ☐ Peritoneal/Ascites ☐ Pleural ☐ Pericardial
☐ Cerebrospinal Fluid (CSF)
☐ Urine: ☐ Voided ☐ Instrumented (catheterized, post-procedure, etc.)
☐ FNA, site/laterality: _____
☐ Other (*please specify*): _____
Additional information/comments:

Diagnosis Code/Verbiage:

Service requested: ☐ Global – technical AND interpretation ☐ Interpretation ONLY ☐ Technical ONLY

PATHOLOGY USE ONLY

Materials received: ☐ Slide(s), Qty: ☐ Block(s), Qty:		Date received:
AHWFB MRN:	HAR #:	CSN #:
AHWFB Case ID:	Initials:	

ORDERS