



PATHOLOGY & CYTOLOGY LABORATORIES, INC.
 CHIPPS, CAFFREY & DUBILIER, P.S.C.

290 BIG RUN ROAD
 LEXINGTON, KY 40503-2903
 (859) 278-9513
 WATS 1-800-264-0514
 FAX 1-859-277-6063

ACCESSION NUMBER

USE ADDRESSOGRAM STAMP HERE

**BILLING INFORMATION
 (MUST BE CHECKED)**

- ACCOUNT
- PATIENT
- INSURANCE
- IN-PT. OUT-PT.
- _____

PATIENT INFORMATION (PLEASE PRINT) **SOCIAL SECURITY NO. REQUIRED**

PATIENT NAME: LAST _____ FIRST _____ MI _____ CLIENT REF # _____

SEX M F DATE OF BIRTH _____ DATE COLLECTED _____ REQUESTING PHYSICIAN (REQUIRED) _____

ADDITIONAL COPY OF REPORT TO: (ADDRESS REQUIRED) _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING INFORMATION PLEASE COMPLETE BILLING & INSURANCE INFORMATION - ATTACH COPY OF INS. CARD(S)

ADDRESS REQUIRED FOR ALL PATIENTS

BC/BS BGFH HUMANA AETNA UHC KY UHC OTHER

POLICY ID# _____

ADDRESS (INCLUDE APT #) _____ APT. # _____ GROUP _____ INSURANCE NAME _____

CITY _____ STATE _____ ZIP code _____ INS. ADDRESS _____

TELEPHONE NO. HOME _____ TELEPHONE NO. WORK _____ CITY/STATE _____ ZIP _____

RESPONSIBLE PARTY/POLICYHOLDER (IF OTHER THAN PATIENT) _____

MEDICARE ID# _____ **ABN REQUIRED**

ADDRESS (INCLUDE APT #) _____

MEDICAID ID# _____

PASSPORT ID# _____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYER _____ self spouse other RELATIONSHIP _____ KENPAC DR. _____ KENPAC # _____

REQUIRED CERVICO VAGINAL CYTOLOGY INFORMATION

SOURCE: <input type="checkbox"/> VAGINAL <input type="checkbox"/> CERVICAL <input type="checkbox"/> ENDOCX <input type="checkbox"/> VAG CUFF	REQUEST <input type="checkbox"/> ROUTINE (ABN) <input type="checkbox"/> DIAGNOSTIC (ICD-9) <input type="checkbox"/> HX ABN PAP <input type="checkbox"/> HX GYN CA	PAP TEST <input type="checkbox"/> THIN PREP WITH HPV IF ASCUS <input type="checkbox"/> THIN PREP WITH HPV REGARDLESS <input type="checkbox"/> THIN PREP ONLY <input type="checkbox"/> HPV ONLY	ANCILLARY TESTS <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> GC <input type="checkbox"/> HERPES <input type="checkbox"/> VAGINOSIS PANEL	DX CODES FOR ANCILLARY TESTS <input type="checkbox"/> DISCHARGE 623.5 <input type="checkbox"/> PELVIC PAIN 625.9 <input type="checkbox"/> OTHER	LMP _____ HIGH RISK FOR CERVICAL CANCER <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS: (SPECIFY OTHER HX AND ICD - 9 CODES): _____ _____ _____
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CHECK ALL APPLICABLE BOXES

PHYSIOLOGIC STATE <input type="checkbox"/> PREGNANT V22.1 <input type="checkbox"/> POST PARTUM V24.2 <input type="checkbox"/> MENOPAUSAL 627.2 <input type="checkbox"/> POST MENOP. BLD 627.1 <input type="checkbox"/> POST MENOPAUSAL 627.9	MEDICAL THERAPY <input type="checkbox"/> ESTROGENS V67.59 <input type="checkbox"/> BC "PILL" V25.41 <input type="checkbox"/> DEPO <input type="checkbox"/> IUD V25.42 <input type="checkbox"/> RADIATION V67.1 <input type="checkbox"/> CHEMO V67.2	SURGICAL HISTORY <input type="checkbox"/> T. HYSTERECTOMY <input type="checkbox"/> P. HYSTERECTOMY <input type="checkbox"/> T. OOPHORECTOMY <input type="checkbox"/> CONE <input type="checkbox"/> LAP SUPRA CX HYST	POSITIVE CLINICAL FINDINGS: <input type="checkbox"/> ABN BLEEDING 626.6 <input type="checkbox"/> VAGINITIS 616.10 <input type="checkbox"/> CERVICITIS 616.0 <input type="checkbox"/> HPV 079.4 <input type="checkbox"/> ATROPHIC VAGINITIS 627.3	<input type="checkbox"/> POLYP 622.7 <input type="checkbox"/> LEKOPLAKIA 622.2 <input type="checkbox"/> DISCHARGE 623.5 <input type="checkbox"/> EROSION 622.0	DATE/PREV PAP _____ READ BY <input type="checkbox"/> PCL OTHER (WHO?) _____ DATE/PREV BX _____ READ BY <input type="checkbox"/> PCL OTHER (WHO?) _____
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NON-GYNECOLOGIC CYTOLOGY INFORMATION REQUIRED

CLINICAL HISTORY _____ CLINICAL DIAGNOSIS/ICD-9 CODES _____

FNA SOLID MASS CYSTIC MASS

BREAST ASP PAROTID/SALIVARY
 _____ LYMPH NODE
 _____ THYROID

SPECIMEN TYPE-PLEASE MARK APPROPRIATE BLOCK(S)

SPUTUM CATH URINE PERICARDIAL PELVIC WASH NIPPLE SMEAR OTHER (LIST) _____
 P.B. SPUTUM VOIDED URINE PERITONEAL CSF VULVA/LABIA _____
 BRONCH WASH BLADDER WASH PLEURAL BREAST CYST OVARY _____
 BRONCH BRUSH _____ ABDOMEN DRAINAGE TZANCK SMEAR _____

ANATOMIC LOCATION (CHECK ALL APPLICABLE BOXES)

RIGHT UPPER LOBE LOWER LOBE _____
 LEFT MIDDLE LOBE _____

COMMENTS

NO. OF SPECIMENS SUBMITTED ON REQUISITION: _____
 SPECIMEN (FLUID) VOLUME: _____
 WAS A TISSUE SAMPLE TAKEN AT THIS TIME? YES NO

FOR CYTOLOGY USE ONLY

<input type="checkbox"/> 88104 NG11	<input type="checkbox"/> 88107 NG14	<input type="checkbox"/> 88110 NG23	<input type="checkbox"/> 88162 NG>5SL	<input type="checkbox"/> 88165 FNA3	<input type="checkbox"/> 88312 _____	SPECIMEN PREPARATIONS	<input type="checkbox"/> SMEARS
<input type="checkbox"/> 88105 NG12	<input type="checkbox"/> 88108 NG21	<input type="checkbox"/> 88111 NG24	<input type="checkbox"/> 88163 FNA1	<input type="checkbox"/> 88170 FNAASP	<input type="checkbox"/> 88313 _____	<input type="checkbox"/> THIN PREP	<input type="checkbox"/> CELL BLOCK
<input type="checkbox"/> 88106 NG13	<input type="checkbox"/> 88109 NG22	<input type="checkbox"/> 88161 NG5SL	<input type="checkbox"/> 88164 FNA2	<input type="checkbox"/> 88173 FNAINT	<input type="checkbox"/> _____	<input type="checkbox"/> CYTOSPIN	<input type="checkbox"/> OTHER