SPECTRUM HEALTH

REQUISITION
ANATOMIC PATHOLOGY

Org ID #: 00_____
*Organization Name: _____

*Organization Address: _____

*City: _____ *St._____ *Zip:_____

*Phone:_____ *Fax:_____

*Order Provider: _____
Please print. Use full provider name, no nicknames or initals
***All information required for valid order**
Label specimen with 2 patient identifiers (full name and date of birth).

*DATE ORDERED	DATE COLLECTED	TIME COLLECTED	INITIALS COLLECTED

***PATIENT INFORMATION**

NAME LAST FIRST MIDDLE INT.

ADDRESS PHONE

CITY STATE ZIP

SEX | MARITAL STATUS | BIRTH DATE | CELL PHONE

Label specimen with 2 patient identifiers (full name and date of birth). Failure to do so may result in cancellation and recollection.

***DIAGNOSIS/ICD CODES**

1st _____

2nd _____

Other _____

INSURANCE INFORMATION

Providers submitting SPECIMEN orders please attach copy(s) of Insurance cards (front and back). Please indicate Primary and Secondary.

Provider Signature _____

Additional report to: Provider _____ **Fax** _____

Order Comment _____

CLINICAL INFORMATION FOR HISTOLOGY AND CYTOLOGY

PERTINENT CLINICAL INFORMATION/REASON FOR EXAM
(examples: history of malignancy, pertinent laboratory studies, radiology studies)

Required for breast tissue only

Cold ischemia start time _____
Formalin fixation START time _____
Total cold ischemia time _____
Formalin fixation STOP time _____
Total formalin fixation time _____

MEDICAL CYTOLOGY FLUID COLLECTION (Test code 46)

- ☐ Peritoneal Fluid
- ☐ Pleural Fluid ☐ Right ☐ Left
- ☐ Cerebrospinal Fluid
- ☐ Bronchial Washing ☐ Right ☐ Left
- ☐ Bronchial Lavage ☐ Right ☐ Left
- ☐ Bronchial Brushing ☐ Right ☐ Left
- ☐ Sputum
- ☐ Cyst Fluid, Source _____
- ☐ Urine, Voided
- ☐ Urine, Catheterized
- ☐ Bladder Washing
- ☐ Renal Pelvic Fluid/Washing ☐ Right ☐ Left
- ☐ Esophageal brushing ☐ Right ☐ Left
- ☐ Nipple Secretion
- ☐ Other (specify) _____

FINE NEEDLE ASPIRATION (FNA, Test Code 202)

- ☐ Breast ☐ Right ☐ Left
- ☐ Wang Needle Aspirate, Specifiy site _____
- ☐ Thyroid ☐ Right ☐ Left ☐ Isthmus
- ☐ Lymph Node, Specifiy site _____
- ☐ Salivary Gland, Specifiy site _____
- ☐ Skin/Subcutaneous (specify site) _____
- ☐ Other (specify) _____

GYNECOLOGICAL COLLECTION (Mandatory for PAP testing and GYN Biopsy)

LMP_____ Previous PAP (date) _____ Abnormal PAP (date) _____ Pregnant (# of weeks) _____ Post-partum (# of weeks) _____

Menopause (yrs) ____ Hyst-Subtotal (has cervix) ____ Hyst-Total (no cervix) ____ Hormone Therapy ☐ No ☐ Yes, specify _____

PAP/HPV TESTING (Both Source and Test required)

Source	Test
☐ Screen – cervical	47 ☐ PAP – No reflex HPV
☐ Screen – vaginal	52 ☐ PAP – HPV if ASCUS/AGUS
☐ Diagnostic – cervical	55 ☐ PAP – HPV if NIL/ASCUS/AGUS
☐ Diagnostic – vaginal	

STD TESTING (Please indicate specimen source)

- ☐ 8229 Chlamydia-PCR _____
- ☐ 8227 Chlamydia/GC-PCR _____
- ☐ 7591 Gonococcus (GC)-PCR _____
- ☐ 7025 Herpes Simplex PCR for Lesions _____
- ☐ 7044 Chlamydia NAAT-APTIMA _____
- ☐ 7046 Chlamydia/GC NAAT-APTIMA _____
- ☐ 7045 Gonococcus (GC) NAAT-APTIMA _____
- ☐ 7043 Trichomonas NAAT-APTIMA _____

COLLECTION FOR TISSUE PATHOLOGY (Test Code 45)

Preservative TISSUE(S) REMOVED (Please no abbreviations)

A _____
B _____
C _____
D _____
E _____

☐ Consultation (indicate specimen source and attach previous reports if indicated):

_____

COLLECTION FOR TISSUE PATHOLOGY FRESH (Test Code 35)

No Preservative TISSUE(S) REMOVED (Please no abbreviations)

A _____
B _____
C _____
D _____
E _____

_____

NOTE: FOR MEDICARE PATIENTS, PLEASE ATTACH COMPLETED ABN FORM CMS-R 131 AS NEEDED
MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS, CERTAIN EXCEPTIONS MAY APPLY
***INDICATES INFORMATION REQUIRED FROM OFFICE FOR VALID WRITTEN ORDER SPECTRUM HEALTH LABORATORY SERVICES 616.774.7721**

White - Laboratory Yellow - Laboratory Pink - Laboratory Gold - Physician