Instructions for Completion of a Requisition

Laboratory Requirements For Requisition And Diagnostic Information

- Provide a completed requisition, including all patient demographics.
- Verify at each visit patient’s current insurance and demographic information.
- Verify that the requisition reflects current insurance and demographic information. Indicate on the requisition if there are any changes. Example: “This is a new address.”
- Indicate married name and maiden name on the requisition if there has been a recent change.
- Social Security number is very important to establish the patient’s Medical Record Number and to identify the patient.
- Please provide a diagnosis to support Medical Necessity for each test order. An appropriate diagnosis would be a disease state, a sign, or a symptom. Never use “R/O” or “?” for a diagnosis. The diagnosis of “normal pregnancy” will not cover all the tests you may feel are necessary for the treatment of your patient. Example:
  — Urine culture: Please provide a sign or a symptom that your patient is experiencing such as urinary frequency, dysuria, or pain with urination
  — DNA testing for cystic fibrosis: Two codes are necessary. Antenatal screening (V728.8) for cystic fibrosis (V77.6), indicate if any family history. If patient is not pregnant, V77.6 is sufficient.
  — Hepatitis C: Exposure to hepatitis C, known hepatitis C carrier (V01.7) is correct or exposure to hepatitis C with pregnancy.
- We receive many requisitions with no diagnosis. The laboratory can never assume a diagnosis. If you order a prenatal profile, we cannot assume the diagnosis is pregnancy.
- If your office uses an internal form for ordering laboratory tests, it must have an area to write in the diagnosis. This will prompt your staff to always provide the diagnosis.

Help Is Available
If you have any questions regarding the appropriate diagnosis to support Medical Necessity, please call laboratory Client Services at 781-306-6915.
Semen Collection Instructions

HALLMARK HEALTH
CLINICAL LABORATORY SERVICES
INSTRUCTIONS FOR SEMEN COLLECTION
AND SPECIMEN IDENTIFICATION

PLEASE READ the following instructions and complete the form with the appropriate information.

A. Abstain from intercourse or ejaculation for two days prior, but no longer than five days.
B. Urinate immediately prior to collection (do not use soap).
C. Obtain the specimen by masturbation only. No lubricants, condoms, vaginal or oral stimulation, etc. should be used.
D. Collect specimen in a sterile container, labeled with name, DOB and time of collection.
E. After collection, place the specimen container, tightly capped, in the bag provided, and return promptly to Melrose Wakefield Hospital Laboratory, 1st Floor Out Patient Services.
F. It is recommended the specimen be collected at MWH Hospital. If that is not possible, please consider the following limitations:
   • Protect specimen from extreme temperatures during transport to MWH Laboratory.
   • Take precautions to maintain the temperature of the specimen between room temperature 68° F and body temperature 98.6°F.
   • Write name, D.O.B., date and time of collection on label.
   • Within one hour of collection, deliver labeled specimen container directly to Melrose Wakefield Hospital Laboratory, 1st Floor Out Patient Services.
   • If you cannot keep this appointment, please call Ancillary Support at 781-338-7111 to cancel and reschedule.

G. Semen Collection for Fertility Studies:
   • The physician’s office or the patient must call and schedule an appointment with Ancillary Support at 781-338-7111. Scheduling must receive a test order from the doctor before the patient may call to schedule an appointment. FAX 781-338-7110.
   • Specimens are ONLY accepted Monday- Friday 8:00 a.m.-2:00p.m.
   • Within one hour of collection, deliver labeled specimen container directly to the 1st Floor, Melrose Wakefield Hospital Out Patient Services.
   • If you cannot keep this appointment, please call Ancillary Support at 781-338-7111 to cancel and reschedule.

H. Post Vasectomy specimens are accepted at any time and do not need to be scheduled.

PLEASE COMPLETE THE FOLLOWING AND BRING THIS FORM WITH YOU

DATE: ____________________ Time of Collection: ____________________

Patient’s Name: ____________________

Referring Physician: ____________________

Length of Abstinence (#of days since last ejaculation or sexual intercourse): ________________

PLEASE CHECK APPROPRIATE INFORMATION IN EACH SECTION:

Collection Site Lab______ Other ________

Transportation Problems: Yes______ No______ (i.e.: exposure to extreme temperature)

Specimen Collection: _____Collected Entire Specimen
                      _____Missed First Portion of Ejaculate
                      _____Missed Middle Portion of Ejaculate
                      _____Missed Last Portion of Ejaculate

Type of Test: _____Semen Analysis for Fertility Studies
              _____Semen Culture
              _____Post Vasectomy
# Integrated Genetics Requisition

## Patient Information
- **Name:** [Redacted]
- **Address:** [Redacted]
- **City:** [Redacted]
- **State:** [Redacted]
- **Zip:** [Redacted]

## Clinical Information

### Single Gene Disorders/Diseases
- **Angelman Syndrome:**
- **Maple syrup urine disease:**
- **Mucopolysaccharide type IV:**
- **Niemann-Pick type A:**
- **Pelizaeus-Merzbacher:**
- **Tay-Sachs disease:**
- **Tay-Sachs disease only:**
- **Usher syndrome type II:**
- **Walker-Warburg syndrome:**

### Thrombophilia
- **Factor V Leiden:**
- **Protein C:**
- **Protein S:**
- **Protein C and S:**

### Prenatal Testing
- **Chromosomal disorders:**
- **Single gene disorders:**
- **Multifetal:**
- **Other:**

## Inherited Carrier Testing
- **Autosomal recessive:**
- **Autosomal dominant:**
- **X-linked:**

## Cyto genetic/FSH/In Vitro Fertilization
- **100: Amniotic fluid chromosomes:**
- **287: Oocyte transfer (12.5 mm diameter):**
- **300: AI-ART:**
- **110: CVS chromosomes:**
- **105: In Vitro Fertilization (IVF):**

## Billing Information
- **Medicaid:**
- **Medicare:**
- **Insurance:**
- **Client:**
- **Self-Pay:**

## Genetic Counselor
- **Name:** [Redacted]
- **Phone:** [Redacted]

## Laboratory Information
- **Test:** [Redacted]
- **Result:** [Redacted]
Maternal Serum/Plasma Screening

1. The purpose of maternal serum/plasma screening is to identify pregnancies that may be at increased risk for open neural tube defects (ONTD), Down syndrome, trisomy 18, or trisomy 13.

2. The screening test I am testing is (circle one):
   - Harmony™ Prenatal Test — detects >99% trisomy 21, >99% trisomy 18, 10% trisomy 13, and X and Y aneuploidy and sex determination. Accuracy of determining fetal sex is >99%, see aneuploidies varies by condition; no information about ONTD
   - FirstScreen™ — detects 99% of Down syndrome and 99% of trisomy 18; no information about ONTD
   - SequentialScreen™ — detects 99% of ONTD, 96% of Down syndrome, and 99% of trisomy 18
   - IntegratedScreen™ — detects 99% of ONTD, 99% of Down syndrome, and 99% of trisomy 18
   - MSAAP — detects 99% of ONTD, no information about Down syndrome or trisomy 18

3. Not all affected fetuses can be detected; some will be missed by any of these screening tests.

4. Abnormal screening results may indicate the need for further testing, such as ultrasound and/or CVS or amniocentesis.

DNA Testing

1. The purpose of my DNA test is to determine whether I, my fetus, or fetal testing is ordered, have mutation(s) or genetic alteration known to be associated with the following genetic condition or disease:

2. This testing is done on a small sample of blood; in some cases a mouthwash sample can be used. For the fetus, testing is done on amniotic fluid, CVS or fetal blood.

3. Mutations and alterations are often different in different populations. I understand that the laboratory results are accurate information about my family history and ethnic background for the most accurate interpretation of the test results.

4. When DNA testing shows a mutation or alteration, then the person is a carrier or is affected with the condition or disease tested for; or, in the case of cancer testing, the person is a carrier of a mutation or alteration that may be associated with an increased risk for certain cancers compared to the general population. Consulting a doctor or genetic counselor is recommended to learn the full meaning of the results and to learn if additional testing might be necessary.

5. When the DNA testing does not show a known mutation or alteration, the chance that the person is a carrier or is affected is reduced or, in the case of cancer genetic testing, the person’s risk for certain cancer(s) compared to the general population will depend on additional personal factors. There is still a chance to be a carrier or to be affected because the current testing cannot find all the possible changes within a gene.

6. In some families, DNA testing might discover non-paternity (someone who is not the real father), or some other previously unknown information about family relationships, such as adoption.

Genetic Amniocentesis

1. The purpose of amniocentesis is to detect certain birth defects, including most fetal chromosome disorders and neural tube defects.

2. My reason for having amniocentesis is:

3. Before the amniocentesis I will have an ultrasound to help locate the placenta and fetus. Ultrasound may also detect twins, incorrect dating of the pregnancy, and some, but not all, physical defects in the fetus.

4. Amniocentesis involves inserting a needle through the woman’s abdomen into the fluid in her uterus. A small amount of fluid (less than 1 ounce) is taken out. There may be some discomfort when the needle is inserted.

5. There are serious complications in less than 1% of amniocentesis procedures. The most serious complication is miscarriage. Other possible, but rare, serious complications include hemorrhage, infection, or injury to the fetus. Minor complications include cramping, vaginal spotting, slight leakage of amniotic fluid, and soreness where the needle was inserted. Early amniocenteses (11-14 weeks gestation) may result in a slightly higher rate of miscar rate (0.4% - 1.9% for 11-14 weeks gestation) compared to late amniocentesis (after 16 weeks gestation).

6. Fewer than 1 in 100 amniocenteses need to be repeated because not enough fluid is obtained in the first attempt. Occasionally, even though fluid is obtained, a diagnosis cannot be made and the amniocentesis needs to be repeated or further testing might be necessary.

7. The standard testing performed on an amniotic fluid sample is chromosomal analysis, which can identify over 90% of chromosomal disorders, and AFP (alpha fetoprotein) analysis, which can identify over 90% of open neural tube defects. Testing for other conditions will not be performed unless indicated in (1) above.

8. Normal test results do not guarantee the birth of a normal child. As in any laboratory test, there is a small possibility of error, and maternal cells may contaminate the sample. In addition, 3-4% of all pregnancies have birth defects which cannot be detected by testing amniotic fluid or by ultrasound examination.

Additional items of consent/refusal applicable to any of the above screening/testing

1. In the case of twins or other multiple fetuses, the results may pertain to only one of the fetuses.

2. In the case of abnormal diagnostic results, the decision to continue or to terminate the pregnancy is entirely mine.

3. The decision to consent, or to refuse any of the above procedures/testing is entirely mine.

4. No test(s) will be performed and reported on my sample other than those authorized by my doctor and any unused portion of my original sample will be destroyed within 2 months of receipt of the sample by the laboratory.

5. My doctor may release my pregnancy outcome or ultrasound and amniocentesis results to Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies who is used for statistical analysis of the laboratory’s performance.

6. LCAH, its subsidiaries and affiliated companies will disclose the test results only to the doctor named below, or to his/her agent, unless otherwise authorized by the patient or required by law.

7. My signature below indicates that I have read, understood, and agree to the above information and I understand: I have read or have had explained to me the specific disease(s) or condition(s) tested for, and the specific test(s) I am having, including the test description, principles, and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated. I know that genetic counseling is available to me before and after the testing. I have all the information I want and all my questions have been answered.

YES: I REQUEST that Dr./or an associate physician perform amniocentesis and/or the genetic screening or testing marked above.

.patient signature
.date
.obtained by

NO: I DECLINE to have amniocentesis, and/or the genetic screening/testing offered to me. I understand and accept the consequences of this decision.

.patient signature
.date
.obtained by

California, Georgia, and New York have statutes requiring laboratories to send confidential results of certain genetic tests to state or federal health agencies for monitoring the detection of birth defects. It is a standard of care for physicians to obtain informed consent for genetic testing. This model consent form is designed to address the requirements of New York State Civil Rights Law Section 794 and Massachusetts General Law Chapter 111, Section 79G. Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies require that all reproductive genetic testing sent to any of our laboratories be accompanied by the signed attestation on the form of this Test Requisition Form. Relevant educational materials are also available through LCAH.

<table>
<thead>
<tr>
<th>BRCAassure™ Test Components</th>
<th>Comprehensive BRCA1/2 Analysis: Includes full gene sequencing and duplication/delusion screening in BRCA1 and BRCA2 genes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashkenazi Jewish BRCA Panel:</td>
<td>Includes screening for three known pathogenic variants; two in BRCA1 gene, one in BRCA2 gene</td>
</tr>
</tbody>
</table>

Integrated Genetics is a brand used by Strategia Genetic Laboratories, LLC, a wholly-owned subsidiary of Laboratory Corporation of America Holdings. 6275 Laboratory Corporation of America Holdings, Inc. rights reserved. 2019 v.11112013
**Integrated Oncology Requisition**

**New York Client Services**

| (800) 447-5816 | (212) 689-9322 |

| **DIAGNOSTIC** |

| www.integratedoncology.com |

---

**PATIENT LAST NAME**

**FIRST NAME**

**MIDDLE NAME**

**Gender**

**Date of Birth**

**Address**

**Home Phone**

**Work Phone**

| **Social Security #**

| **City**

| **State**

| **Zip**

| **Referring Physician**

| **Treatment Physician**

| **Physician/Authorized Signature**

| **Specimen and Clinical Information**

| **Tests and Services, Continued**

| **Clinical Information**

| **Clinical Data** (attach clinical history and pathology reports)

| **Tumor Analysis**

| **DNA Probes/S. Phase & p53** (HNC) |

| **Lymph Node and Bone Marrow Micrometastases Detection**

| **UroVision® FISH**

| **Infectious Agents (HIC)**

| **In Situ Hybridization (ISH)**

| **HPV Tissue Testing**

| **Consultative Services**

| **Individual Antibodies**

| **Billing Information**

| **Insurance Company Name**

| **Policy #**

| **Group #**

| **Relation to Insured**

| **Self**

| **Spouse**

| **Child**

| **Other**

| **Patient Signature**

---

The specimen information, tumor analysis, tests and services, clinical information, consultative services, and billing information sections are filled out with various medical details, including patient demographics, test details, and billing information. The document is a comprehensive form used for Integrated Oncology Requisition purposes, detailing medical procedures, tests, and services required for patient care.
**Hematopathology Requisition**

**Client Information**

**MELROSE-WAKEFIELD HOSPITAL - 2438**
585 Lebanon St.,
Melrose, MA 02176
PH: (781) 979-3839
FAX: (781) 979-3142

Requisition completed by: __________________ Date __________________

Ordering Physician (please print): __________________

Ordering Physician Signature: __________________

**Specimen Information**

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Collection Date</th>
<th>Collection Time</th>
<th>Specimen Type</th>
<th>Collection Date</th>
<th>Collection Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td>AM / PM</td>
<td>Bone Marrow</td>
<td>/ /</td>
<td>AM / PM</td>
</tr>
<tr>
<td>Fresh Tissue</td>
<td>/ /</td>
<td>AM / PM</td>
<td>Other</td>
<td>/ /</td>
<td>AM / PM</td>
</tr>
<tr>
<td>Fluid CSF</td>
<td>/ /</td>
<td>AM / PM</td>
<td>Other</td>
<td>/ /</td>
<td>AM / PM</td>
</tr>
<tr>
<td>Other</td>
<td>/ /</td>
<td>AM / PM</td>
<td>Other</td>
<td>/ /</td>
<td>AM / PM</td>
</tr>
</tbody>
</table>

**Clinical Diagnosis**

(Provide the patient's clinical diagnosis)

**Billing Information**

- Please attach all relevant clinical history and pathology reports
- New Diagnosis
- In Remission
- See Attatched for Patient Demographics

**Coding Information**

- Diagnosis Code/ICD-9 Code (required): ___________________________

**Hematopathology Testing**

**Flow Cytometry**

- Standard Leukemia/lymphoma Panel
- Extended Leukemia/Lymphoma Panel with complete plasma cell evaluation
- PhM (Global)
- Additional Global Markers

**Cytogenetics**

- Oncology Chromosome Analysis
- Other

**Other Testing**

- NeoTYPE™ AML Prognostic Profile
- NeoTYPE™ CLL Prognostic Profile
- NeoTYPE™ Lymphoma Profile
- NeoTYPE™ MDS/CMML Profile
- NeoTYPE™ Spliceosome Mutation Profile
- NeoARRAY™ SNP/Cytogenetic Profile

**FISH**

- Hematologic FISH Panels
  - MDS - For unexplained Anemia/Cytopenia
  - MM/MGUS
  - CLL
  - NHL
  - MHN
  - AML
  - Eosinophilia

**Individual Probes**

All panel probes can be ordered individually by using the "Other" write-in box.
- ALK/Lymphoma (2p23)
- BCR/ABL/AS 19/22
- PML/RARA (15/17)
- Other

**Molecular Genetics**

- ABL1 kinase (Gleevec® resistance)
- 8-Cell gene rearrangements
- B-Cell & T-Cell gene rearrangements
- BCR-ABL1, 19/22 - Reflex to ABL1
- CEBPA
- CLMolecular Prognostic Panel
- FLT3
- JAK2 V617F - Reflex to JAK2 Exon 12-14
- MNF Reflex Panel
- NPM1
- PML-RARA, 15/17
- Other
### Laboratory Imaging Requisition

**Hallmark Health System**

Patients please report to registration before going to the laboratory at the main campus.

Please print:  
- **Patient:**  
- **Street:**  
- **City:**  
- **Zip:**  
- **D.O.B.:**

**Ordering Physician:**

1) **Primary Insurance**
   - **Name and Address:**  
   - **Insurance Certificate #:**  
   - **Patient Buffer:**  
   - **Group Number:**  
   - **Mass Health Card Number:**

2) **Secondary Insurance**
   - **Name and Address:**  
   - **Insurance Certificate #:**  
   - **Patient Buffer:**  
   - **Group Number:**  
   - **Mass Health Card Number:**

### Diagnosis, Sign or Symptom Required with each test ordered.

**ICD-9-CM codes should not be interpreted as proof of medical necessity.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1221</td>
<td>Acute Myocardial Infarction</td>
</tr>
<tr>
<td>559.4</td>
<td>Cerebrovascular Disease</td>
</tr>
<tr>
<td>713.3</td>
<td>Abdominal Aneurysm</td>
</tr>
<tr>
<td>745.1</td>
<td>Acute Appendicitis</td>
</tr>
<tr>
<td>745.8</td>
<td>Acute Cholecystitis</td>
</tr>
<tr>
<td>745.9</td>
<td>Acute Pancreatitis</td>
</tr>
<tr>
<td>746.4</td>
<td>Acute Esophagitis</td>
</tr>
<tr>
<td>746.8</td>
<td>Acute Gastritis</td>
</tr>
<tr>
<td>746.9</td>
<td>Acute Colitis</td>
</tr>
<tr>
<td>746.9</td>
<td>Acute Enteritis</td>
</tr>
<tr>
<td>746.9</td>
<td>Acute Intestinal Obstruction</td>
</tr>
<tr>
<td>746.9</td>
<td>Acute Appendicitis</td>
</tr>
<tr>
<td>746.9</td>
<td>Acute Cholecystitis</td>
</tr>
<tr>
<td>746.9</td>
<td>Acute Pancreatitis</td>
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<td>Acute Enteritis</td>
</tr>
<tr>
<td>746.9</td>
<td>Acute Intestinal Obstruction</td>
</tr>
</tbody>
</table>

### Additional Microbiology Tests

- **Bacterial Vaginosis**
- **Candidiasis**
- **Gonorrhea**
- **Chlamydia**
- **Hepatitis**
- **HIV**
- **Syphilis**
- **Tuberculosis**
- **Urinary Tract Infection**
- **Viral Infections**

### Reflex testing performed on additional charge

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT*</td>
<td>Prothrombin Time</td>
</tr>
<tr>
<td>PTT*</td>
<td>Partial Thromboplastin Time</td>
</tr>
<tr>
<td>INR</td>
<td>International Normalized Ratio</td>
</tr>
</tbody>
</table>

### Microbiology Source

- **Bacteriology**
- **Virology**
- **Parasitology**
- **Immunology**

### Laboratory Services

- **Blood Bank**
- **Bone Marrow**
- **Clinical Chemistry**
- **Clinical Microbiology**
- **Immunology**
- **Molecular Biology**
- **Histology**
- **Cytology**
| MM/002030 | Comprehensive Metabolic Panel - Albumin, Alk Phos, Total Bilirubin, CO2, Na, K, Cl, BUN, Ca, Creat, Glucose, SGOT (AST), SGPT (ALT), Total Protein |
| MM/002400 | Basic Metabolic Panel - Na, K, Cl, CO2, Glucose, BUN, Ca, Creat |
| LIPP/002051 | Lipid Panel (fasting - 12 hr) - Total Chol, Trig, HDL, LDL, (Calculated), Coronary Risk Factor |
| LIPP/002076 | Liver Function Panel (Liver Function Panel) - Albumin, Alk Phos, Alb/Lib,岑化 & Direct, SGOT (AST), SGPT (ALT), Total Protein |
| LIPP/002030 | Electrolytes - Na, K, Cl, CO2 |
| LIPP/002030 | Acute Hepatitis Panel - HbsAg, HepCAb, HAVAb, Igm, Hep B Core Ab, IgM |
| FNTL/002030 | Thyroid Panel - TSH, T3, T4, T3 Resist, TSHR Ab, TMA, TMA Ab, TMA-C |
| FNTL/003030 | PPD (tuberculin) Reactor |
| FNTL/003030 | Stool Protein Electrophoresis - Albumin, Total Protein, Alpha 1 Globulin, Alpha 2 Globulin, Beta Globulin, Gamma Globulin, Interpretation |
| FNTL/003030 | TSH* with reflex: If TSH<0.3 permits T3 and T4; If TSH>4.6 permits T4 |
| FNTL/003030 | CBC* (hemogram) - WBC, RBC, HGB, HCT, MCV, MCH, MCHC, RDW, PLT, CT. CRP* will reflect CRP in WBC <5000 OR >10,000 |
| FNTL/003030 | Complete Blood Count* with automated Differential reflex Manual Differential if indicated |
| FNTL/003030 | Urinalysis will reflect microscopic if character is other than clear or if Prox, RBC, Ery, Nit is positive |

Microbiology

- Stool cultures will include E. coli, Salmonella, Shigella, and Campylobacter.
- Throat cultures will only screen for the presence of beta hemolytic A Group A streptococci.
- Susceptibility testing will be performed appropriately by organisms at additional charge.

**NOTE:** Asterisk * Tests include Limited Coverage Tests.

**NOTE:** Ultrasound performed at additional charge.

---

**Please Visit Our Drawing Sites**

**LAWRENCE MEMORIAL HOSPITAL**
Laboratory
170 Governors Avenue
Medford, MA 02155
Phone: 781-306-6850

**Hours of Operation:**
Monday - Friday, 7:00 a.m. - 6:00 p.m.
Saturday, 7:00 a.m. - 12:00 Noon

**LAWRENCE MEMORIAL MEDICAL SERVICES**
Drawing Station
101 Main Street, Suite 116
Medford, MA 02155
Phone: 781-391-2121

**Hours of Operation:**
Monday & Thursday, 7:00 a.m. - 7:00 p.m.
Tuesday, Wednesday & Friday, 7:00 a.m. - 5:00 p.m.

**WOODLAND ROAD STONEHAM**
3 Woodland Road First Floor
Suite 113
Stoneham, MA 02180
Phone: 781-685-3498

**Hours of Operation:**
Monday - Friday, 8:00 a.m. - 5:00 p.m.
Closed for Lunch, 12:30 p.m. - 1:30 p.m.

**MELROSE-WAKEFIELD HOSPITAL LAB**
585 Lebanon Street
Melrose, MA 02176
Phone: 781-979-3151

**Hours of Operation:**
Monday - Friday, 7:00 a.m. - 8:00 p.m.
Saturday & Sunday, 7:00 a.m. - 3:00 p.m.

**MALDEN FAMILY HEALTH**
1st Floor
178 Savin Street
Malden, MA 02148
Phone: 781-338-7443

**Hours of Operation:**
Monday - Tuesday & Thursday, 8:00 a.m. - 4:00 p.m.
Closed for Lunch, 12:30 p.m. - 1:30 p.m.

**READING MEDICAL CENTER**
30 New Crossing Road
Reading, MA 01860
Phone: 781-213-5115

**Hours of Operation:**
Monday, 7:00 a.m. - 7:00 p.m.
Tuesday & Thursday, 7:00 a.m. - 5:00 p.m.
Wednesday & Friday, 7:00 a.m. - 4:00 p.m.

**MEDICAL OFFICE BUILDING**
50 Rowe Street
Melrose, MA 02176
Phone: 781-979-3296

**Hours of Operation:**
Monday - Friday, 7:00 a.m. - 5:00 p.m.
Date of Service ______ / ______ / ______
Lawrence Memorial Campus ______ Melrose Wakefield Campus
781-306-6880 781-979-3135

Submitting Physician: ____________________
Other Physician: ________________________

PATIENT DATA
Name________________________________________         DOB ______ / ______ / ______
Address _____________________________________________________________________________
Phone: (____) _______ Social Security Number: ______ / ______ / ______   □ Male   □ Female

INSURANCE Please provide a copy of the Insurance Card with requisition

PRIMARY INSURANCE   □BC/BS □Medicare □Medicaid □Tufts □HMOBlue □Medex
□Secure Horizons □GIC(State Hancock) □Other _____________
Certificate No.: ____________________ Patient Suffix _______ Group No.: ____________
Mass. Health Card No.: ____________________ Sequence No.: _____________

SECONDARY INSURANCE
Patient Suffix ______ Group No.____ Mass. Health Card No. ____________ Sequence No. ______

SPECIMEN DATA
SOURCE 1: _______ SITE: _______ □Right □Left CLINICAL DX: ________________
SOURCE 2: _______ SITE: _______ □Right □Left CLINICAL DX: ________________
SOURCE 3: _______ SITE: _______ □Right □Left CLINICAL DX: ________________
SOURCE 4: _______ SITE: _______ □Right □Left CLINICAL DX: ________________
SOURCE 5: _______ SITE: _______ □Right □Left CLINICAL DX: ________________

RELEVANT PRIOR BIOPSY/PAP SMEAR?
__________________________________________________________________________

PLEASE CHECK RELEVANT SIGN(S)/SYMPTOMS(S)

OB/GYN
□ abnormal pap
□ abnormal bleeding
□ postmenopausal bleed
□ irregular bleeding
□ amenorrhea
□ thickened endometrium
□ endocervical polyp
□ infertility
□ other

UROLOGY
□ hematuria
□ elevated PSA
□ calculus
□ other ______

DERMATOLOGY
□ keratosis
□ skin lesion
□ texture change
□ other ______

OTHER

□ □ □
**Request for Cytologic Examination**

### Patient Information

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<tr>
<th>LAST NAME</th>
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<th>MIDDLE</th>
<th>DATE OF BIRTH</th>
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### Insurance Information

- **Primary Insurance** (Please provide PPO #)
- **Secondary Insurance**
  - **Source**: Source
  - **Policy #**: Policy #

### Clinical Information

- **CLINICAL INFORMATION**
  - **Source**: Source
  - **Hybrid Capture II HPV Test**: Hybrid Capture II HPV Test

- **Other History (Specify)**: Other History (Specify)

### Comments

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