Collecting Gyn/Cyto Pap Specimens in Office

Laboratory Education

for

Physician Office Staff

April 2013

Completion of Form

ALL REQUESTED INFORMATION MUST BE PROVIDED AND LEGIBLE.

Meadville Medical Center Laboratory Custom Cyto/Tissue Requisition – Quest Diagnostics (1-800-MY QUEST)
751 Liberty Street, Meadville, Pa 16335 – Quest Account 81450
814-333-5511

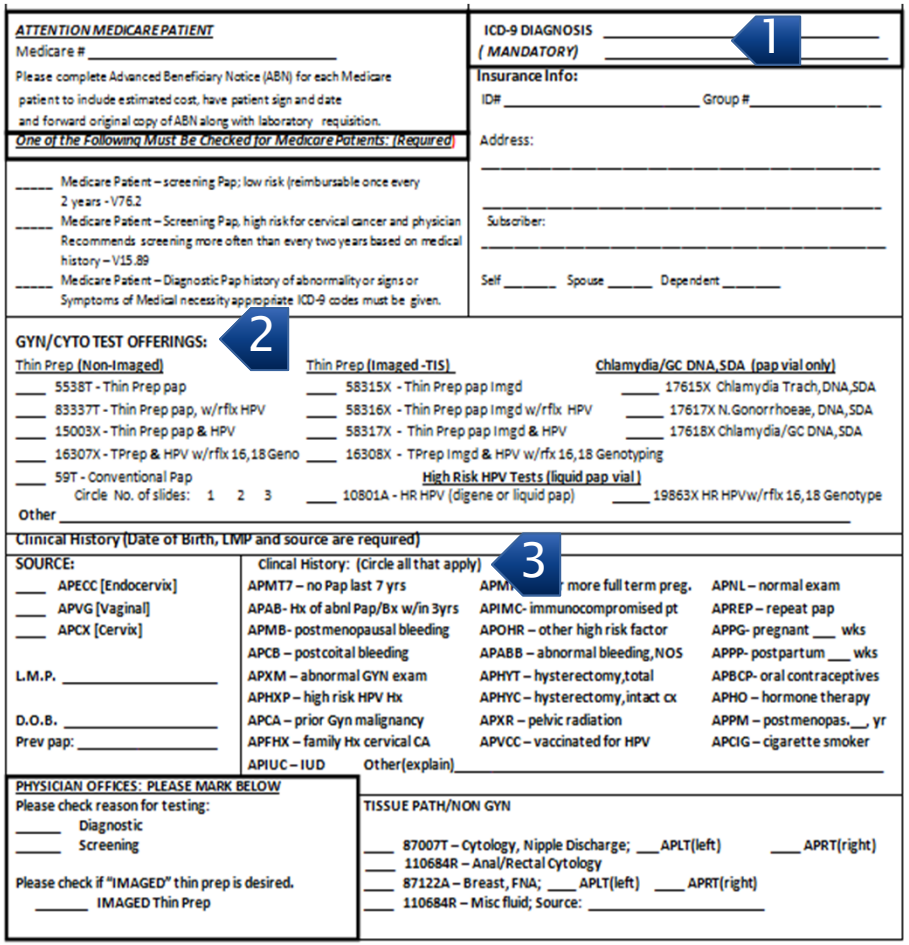
MEDICAL PATIENT DATA			PATIENT AND INSURANCE BILLING INFO
Last name, first name		Location:	Address: Street:_____
Patient Number:	Date of Birth:	Sex: M____ F____	City:_____
Patient ID/Social Security Number	Date Collected	Time Collected:	State:_____ Zip Code: _____
Referring Physician:			Other Copies::
ATTENTION MEDICARE PATIENT Medicare #_____ Please complete Advanced Beneficiary Notice (ABN) for each Medicare patient to include estimated cost, have patient sign and date and forward original copy of ABN along with laboratory requisition.			ICD-9 DIAGNOSIS _____ ***(MANDATORY)*** _____ Insurance Info: ID#_____ Group #_____
One of the Following Must Be Checked for Medicare Patients: (Required)			Address: _____ _____
_____ Medicare Patient – screening Pap; low risk (reimbursable once every 2 years - V76.2 _____ Medicare Patient – Screening Pap, high risk for cervical cancer and physician Recommends screening more often than every two years based on medical history – V15.89 _____ Medicare Patient – Diagnostic Pap history of abnormality or signs or Symptoms of Medical necessity appropriate ICD-9 codes must be given.			Subscriber: _____ Self _____ Spouse _____ Dependent _____

If received specimen is <u>not correctly labeled or request form is not complete</u>, the specimen will be rejected and returned to the sending office for correction. The delay in processing will be dependent upon the receipt of corrected information.

–Cyto/Path Policy

Attaching a patient demographic data sheet is acceptable. Please verify that all requested information is present and labeled on the demographic sheet.

When attaching a demographic sheet, please write the patient name on the lab form, matching the name on sheet provided. This ensures proper identification of lab order.



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ICD-9 DIAGNOSIS _____ 1
(MANDATORY) _____

Insurance Info:
ID# _____ Group #_____
Address:
_____
_____
Subscriber:
_____
Self _____ Spouse _____ Dependent _____

GYN/CYTO TEST OFFERINGS: 2

Thin Prep (Non-Imaged)
___ 5538T - Thin Prep pap
___ 83337T - Thin Prep pap, w/rflx HPV
___ 15003X - Thin Prep pap & HPV
___ 16307X - TPrep & HPV w/rflx 16,18 Geno
___ 59T - Conventional Pap
Circle No. of slides: 1 2 3

Thin Prep (Imaged -TIS)
___ 58315X - Thin Prep pap Imgd
___ 58316X - Thin Prep pap Imgd w/rflx HPV
___ 58317X - Thin Prep pap Imgd & HPV
___ 16308X - TPrep Imgd & HPV w/rfx 16,18 Genotyping

High Risk HPV Tests (liquid pap vial)
___ 10801A - HR HPV (digene or liquid pap)

Chlamydia/GC DNA,SDA (pap vial only)
____ 17615X Chlamydia Trach,DNA,SDA
____ 17617X N.Gonorrhoeae, DNA,SDA
____ 17618X Chlamydia/GC DNA,SDA
____ 19863X HR HPV w/rflx 16,18 Genotype

Other _____

Clinical History (Date of Birth, LMP and source are required)

SOURCE:
___ APECC [Endocervix]
___ APVG [Vaginal]
___ APCX [Cervix]

L.M.P. _____
D.O.B. _____
Prev pap: _____

Clincal History: (Circle all that apply) 3
APMT7 – no Pap last 7 yrs
APAB- Hx of abnl Pap/Bx w/in 3yrs
APMB- postmenopausal bleeding
APCB – postcoital bleeding
APXM – abnormal GYN exam
APHXP – high risk HPV Hx
APCA – prior Gyn malignancy
APFHX – family Hx cervical CA
APIUC – IUD
APM[illegible] more full term preg.
APIMC- immunocompromised pt
APOHR – other high risk factor
APABB – abnormal bleeding,NOS
APHYT – hysterectomy,total
APHYC – hysterectomy,intact cx
APXR – pelvic radiation
APVCC – vaccinated for HPV
APNL – normal exam
APREP – repeat pap
APPG- pregnant ___ wks
APPP- postpartum ___ wks
APBCP- oral contraceptives
APHO – hormone therapy
APPM – postmenopas.__, yr
APCIG – cigarette smoker
Other(explain)_____

PHYSICIAN OFFICES: PLEASE MARK BELOW
Please check reason for testing:
_____ Diagnostic
_____ Screening

Please check if "IMAGED" thin prep is desired.
_____ IMAGED Thin Prep

TISSUE PATH/NON GYN
___ 87007T – Cytology, Nipple Discharge; ___APLT(left) ___APRT(right)
___ 110684R – Anal/Rectal Cytology
___ 87122A – Breast, FNA; ___APLT(left) ___APRT(right)
___ 110684R – Misc fluid; Source: _____

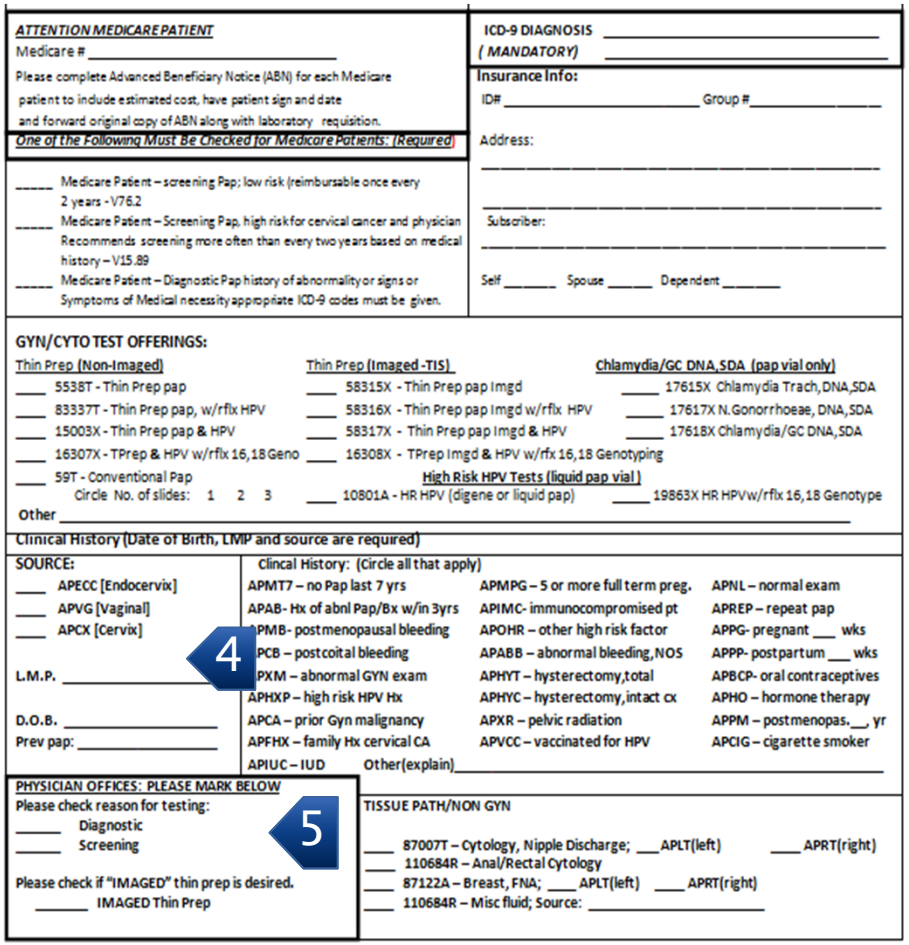
Bold boxes in form are present to draw attention to areas that have been overlooked in the past.

Complete the Following

1. ICD-9 Diagnosis
2. Test options
   - Notice that options are provided as NON-IMAGED or IMAGED-TIS
   - Tissue path/non-gyn options are listed at bottom of the form
3. Clinical history

Non-imaged: Cells are manually reviewed by cytologist/pathologist.

Imaged-TIS: An analyzer scans many more cells than manual methods; reviews, classifies and highlights those of interest prior to review by the cytologist /pathologist.



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ICD-9 DIAGNOSIS _____
(MANDATORY) _____
Insurance Info:
ID# _____ Group #_____
Address:
_____
_____
Subscriber:
_____
Self _____ Spouse _____ Dependent _____

GYN/CYTO TEST OFFERINGS:

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Other _____

Clinical History (Date of Birth, LMP and source are required)

SOURCE:
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4
L.M.P. _____
D.O.B. _____
Prev pap: _____

Clincal History: (Circle all that apply)
APMT7 – no Pap last 7 yrs
APAB- Hx of abnl Pap/Bx w/in 3yrs
APMB- postmenopausal bleeding
PCB – postcoital bleeding
PXM – abnormal GYN exam
APHXP – high risk HPV Hx
APCA – prior Gyn malignancy
APFHX – family Hx cervical CA
APIUC – IUD
APMPG – 5 or more full term preg.
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APXR – pelvic radiation
APVCC – vaccinated for HPV
APNL – normal exam
APREP – repeat pap
APPG- pregnant ___ wks
APPP- postpartum ___ wks
APBCP- oral contraceptives
APHO – hormone therapy
APPM – postmenopas.__, yr
APCIG – cigarette smoker
Other(explain)_____

PHYSICIAN OFFICES: PLEASE MARK BELOW
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5
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Complete the Following

4

- Source
- Last menstrual period (LMP)
- Date of Birth (DOB)
- Date of previous pap

Providing Clinical History and items located in SOURCE box will enable the cytologist and/or pathologist to provide a report with greater clinical significance.

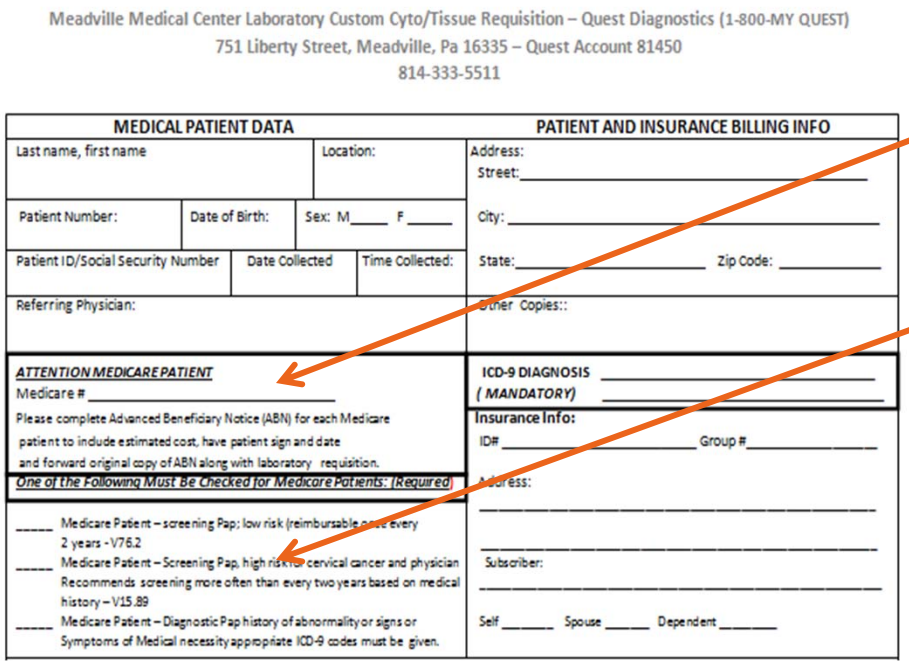
Complete history information = complete reporting data

5

- Diagnostic, Screening and Imaged options

Diagnostic, Screening and Imaged options in the above box are necessary to ensure proper entry is selected in the complex order entry process.

Medicare Patient



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Patient Number:	Date of Birth:	Sex: M____ F____	City: _____
Patient ID/Social Security Number	Date Collected	Time Collected:	State:_____ Zip Code: _____
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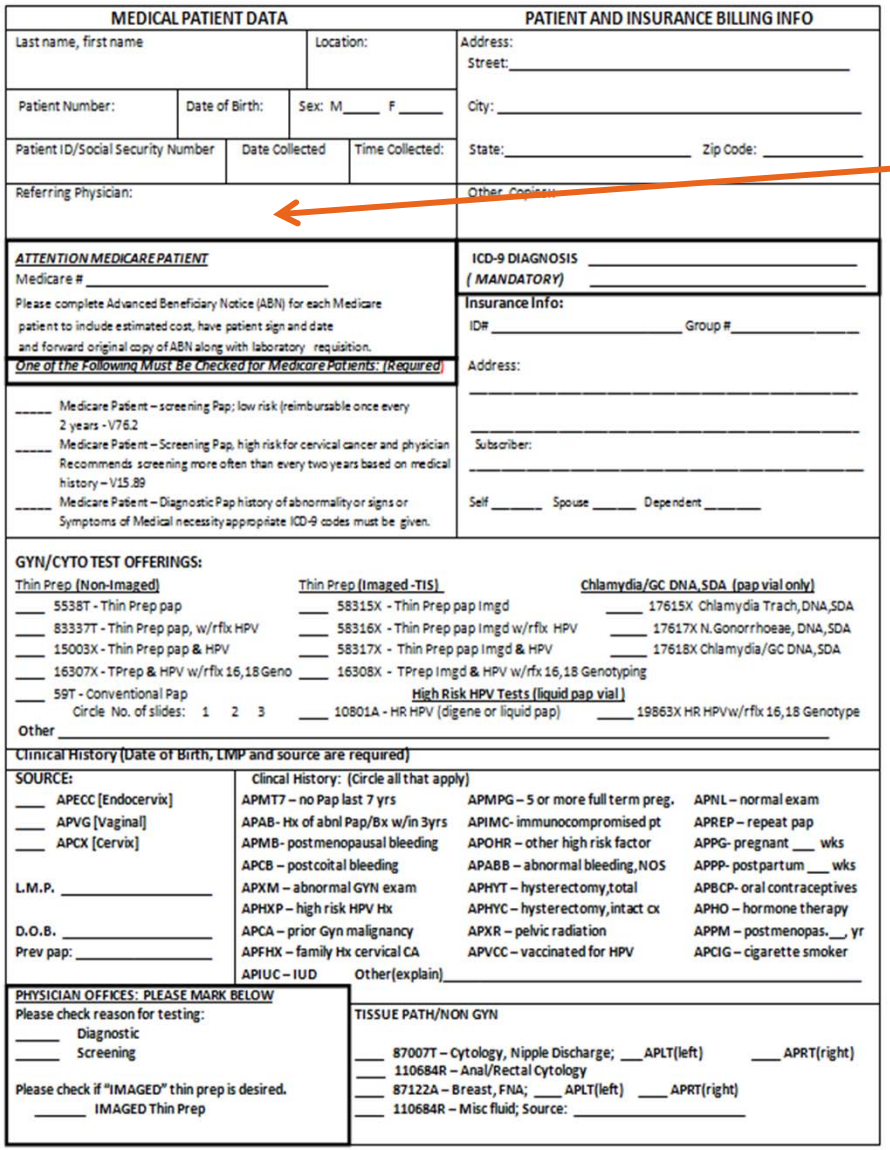
- Record Medicare number in bolded box.
- Choose a Medicare screening or diagnostic option (in box below).
- Complete the rest of the form as directed.

Bold boxes are present to draw attention to areas that have been omitted in the past.

Patient Acknowledgement of Non-Covered Services form is **NO LONGER REQUIRED** – regardless of insurance.



MEDICAL PATIENT DATA

Last name, first name | Location:

Patient Number: | Date of Birth: | Sex: M____ F____

Patient ID/Social Security Number | Date Collected | Time Collected:

Referring Physician:

PATIENT AND INSURANCE BILLING INFO

Address:
Street:_____
City:_____
State:_____ Zip Code:_____
Other Copies:_____

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Non-Physician Practitioner

- Place the NPP name in **Referring Physician** area.
- Following name of NPP, place the name of the physician in charge in **Referring Physician** area.
- (NOTE: NPP's name will appear as "other Dr" on the lab report.)

Site

If applicable, include location of site in "Location" box or top margin.

Automated Patient Result Access Center

(Optional Service)
Results are made available to the patient (after they are received by the physician) via a toll free number.
Negative- prerecorded message informs negative status.
Abnormal- message informs the patient to contact the physician directly.

Patient Card

Quest Diagnostics

To receive confidential information pertaining to your Pap test performed by Quest Diagnostics:

1. Wait **two weeks** from the date of the collection of your Pap test before contacting Quest Diagnostics.
2. Call Quest Diagnostics toll free at **855-697-2739 (855-MYPAPDX)**
3. You will be asked to provide the following information to confirm your identity and meet the data privacy guidelines for releasing test results.
   - Patient Phone Number You Have On File With Your Physician:
   - Your Date of Birth: MM/DD/YY #
   - Your Physician Pin Number: 81450 #
   - Verify First Three Letters of Your Last Name:
   - Verify First Three Letters of Your Physician's First Name:

Please Note: Quest Diagnostics will not be permitted to release your test results in the event that the information you provide does not match the information provided to Quest Diagnostics by your Physician.

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Patient's phone number must be present for system to function.

Specimen Label

Using a sharp #2 pencil or an extra-fine tip permanent marker* write directly on the frosted area of the slide…

Include:

- Initial of first name
- Complete last name
- Patient's date of birth

Legibility is extremely important. The specimen will be returned if labeled slide or vial is not legible.

* Quest lab suggests the use of **Pilot extra-fine point permanent marker** (they are non-smearing).

Patient date of birth is mandatory as CAP 2nd patient identifier.

Packaging

Prepare for transport by placing the following in a biohazard transport bag:

- MMC Cyto/Tissue Requisition
- Specimen

Specimen may be stored at room temp until transported.

Please place form in the outer pouch away from the specimen.

Thank you for completing the

Collecting Gyn/Cyto Pap Specimens in Office educational module.

Please press HERE to return to the main menu.