



CoCoPATH

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CYTOLOGY/ANATOMIC SPECIMEN REQUISITION

CONTRA COSTA PATHOLOGY ASSOCIATES

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PATIENT INFORMATION			
REQUIRED	Last Name	First Name	COLLECTION DATE
	Date of Birth	[] Male [] Female	COLLECTION TIME
	Address		ORDERING PHYSICIAN NAME (Last, First) PLEASE PRINT
	City State Zip		
	Home Number ()	Work Number ()	
BILLING	<input type="checkbox"/> PATIENT <input type="checkbox"/> CLIENT BILL <input type="checkbox"/> INSURANCE: Attach a copy of primary and secondary insurance cards. <input type="checkbox"/> MEDICARE: Medicare patient reviewed and signed advanced beneficiary notice for non-covered services: see back.		PHYSICIAN OFFICE INFORMATION
			COPIES TO: NAME & FAX
		RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Spouse	SPECIAL HANDLING <input type="checkbox"/> STAT <input type="checkbox"/> FRESH
ICD 10 CODES REQUIRED NON-MEDICARE <input type="checkbox"/> Diagnostic ICD 10 _____		ROUTINE GYN EXAM <input type="checkbox"/> Z01.419 w/o ABN findings <input type="checkbox"/> Z01.411 w/ABN Findings <input type="checkbox"/> High Risk HPV Screen ICD 10 _____	

CERVICAL CANCER SCREENING SWAB TEST

CHECK SOURCE

- Cervical- Endocervical
- Cervical – Vaginal
- Vaginal
- Vulvar
- Other _____

WOMEN 21-25 YEARS

- ThinPrep® PAP if ASCUS and above reflex to Aptima® HPV + CT/NG

WOMEN 26-29 YEARS

- ThinPrep® PAP if ASCUS and above, reflex to Aptima® HPV

WOMEN 30-65 YEARS

- ThinPrep® PAP + Aptima® HPV if PAP normal & HPV Positive reflex Genotype 16, 18/45

ADDITIONAL TESTS

- ThinPrep® PAP
- HPV 16, 18/45 High Risk Screen*
- STI PANEL (CT/NG, HPV, TV)
- CT NG CT/NG TV

NON GYN CYTOLOGY

- FNA _____
- Nipple discharge
- Other _____

APTIMA® MULTI-TEST (ORANGE) SWAB

Vaginal

- BV (Bacterial Vaginosis)
- CV (Candida glabrata/species)
- CT/NG/TV
- CT/NG
- TRICHOMONAS (TV)
- VAGINITIS PANEL (BV/CV/TV)
- MGEN Mycoplasma genitalia
- Anogenital** HSV1/HSV2

APTIMA® UNISEX (WHITE/PURPLE) SWAB

Endocervical

- CT/NG
- MGEN
- TV

URINE TEST (YELLOW)

- APTIMA® CT/NG
- MGEN

GYN HISTORY

HISTORY

- Hysterectomy Total Supracervical
- IUD
- Oral Contraceptives
- Hormone Replacement Type:
- High Risk HPV
- LGSIL/HGSIL
- Date of Last Menstrual Period _____
 Regular Irregular
- Pregnant
- Post-Partum
- Post-Menopausal

CLINICAL HISTORY

ANATOMIC PATHOLOGY

TISSUE BIOPSIES

- ENDOMETRIUM
- POC
- D & C TAB
- SKIN TAG
- Cervix ECC LEEP

A. _____
B. _____
C. _____
D. _____

*HR HPV screen includes 14 high risk HPV types and reporting of 16, 18/45

A. Notifier:

B. Patient Name:

C. Identification Number:



Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

OPTION 3. I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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