DAHL-CHASE DIAGNOSTIC SERVICES

CYTOLOGY & SURGICAL PATHOLOGY REQUISITION

Dahl-Chase Diagnostic Services
417 State Street, Suite 540, Bangor, ME 04401
(207) 941-8200 / 1-800-660-1626
www.dahlchase.com

Name ______	Name ______	Name ______
DOB or MRN ______	DOB or MRN ______	DOB or MRN ______
Source ______	Source ______	Source ______

PLEASE PRINT
COMPLETE ALL PATIENT INFORMATION OR ATTACH DEMOGRAPHIC SHEET AND COPY OF INSURANCE CARD(S) (BOTH SIDES)

PATIENT

- **Patient Name (Last, First, MI)**
- **Date of Birth** | **Sex** ☐ M ☐ F ☐ O | Telephone
- Social Security Number | Medical Record Number
- Mailing Address
- City, State, Zip

CLINICIAN

- **Requesting Clinician Name (Last, First)**
- **Clinician Office/Clinic**
- **Collection Date & Time** | Requisition completed by

INSURANCE

- Primary Insurance Name
- Primary Insurance Policy ID | Group Number
- Primary Medical Claims Address, City, State, Zip
- Secondary Insurance Name
- Secondary Insurance Policy ID | Group Number
- Secondary Medical Claims Address, City, State, Zip

Copy to Clinician Name (Last, First, & Office Location)

☐ Correlation with previous or concurrent case: ______

PAP & HPV

Complete ALL Sections Below

Pap and HPV test options on Pap vial (check only one box)

- ☐ **Pap with HPV Co-test** (screening age 30-65*)
- ☐ **Primary HPV with reflex to Pap for HR HPV - Submit Pap Vial** (screening age 25-65*)
- ☐ **Liquid-based Pap Test Only without HPV** (screening age 21-24*)
- ☐ **Pap with reflex HPV for ASCUS** (screening age 21-29*)

*See ASCCP website for guidelines

GC/Chlamydia

- ☐ **GC/Chlamydia Test - submit Cobas PCR Female Swab**

Pap Specimen Source (check one box)

- ☐ **Endocervix/Exocervix**
- ☐ **Vagina**

Previous Pap Date ____/____/____

Menstrual Status (check any that apply)

LMP ___/___/___ ☐ Pregnant ☐ Post Menopause ☐ Post Partum
☐ Hysterectomy cervix present ☐ Hysterectomy cervix not present

REASON FOR TODAY'S TEST - CHECK ONLY ONE BOX FOR BILLING

- ☐ **Routine screening exam (Medicare will cover routine screening once every 2 years, otherwise submit ABN)**
- ☐ **Diagnostic** MUST CHECK SUPPORTING DIAGNOSTIC REASON BELOW (Medicare will cover with signs, symptoms, or history of disease otherwise submit ABN)
- ☐ **High Risk Patient** MUST CHECK HIGH RISK FACTORS BELOW (Medicare will cover patients with high risk factors once every 11 mos, otherwise submit ABN)

DIAGNOSTIC REASON

CHECK ANY THAT APPLY

- ☐ ASCUS ☐ LGSIL ☐ HGSIL
- ☐ Positive HPV ☐ Endometrial CA
- ☐ CIN I ☐ CIN II ☐ CIN III
- ☐ Non-diagnostic Pap
- ☐ Atypical Glandular Cells (AGC)
- ☐ Abnormal bleeding
- ☐ Vaginal Dysplasia
- ☐ Gynecologic Surgery
- ☐ Adenocarcinoma In Situ (AIS)

HIGH RISK FACTORS

- ☐ DES
- ☐ Multiple sexual partners
- ☐ Early onset of sexual activity
- ☐ 2 or fewer neg Paps in last 7 years
- ☐ History of STD
- ☐ Pre-menopausal with cervical/ vaginal cancer in past 3 years
- ☐ Positive HPV

Other Clinical History

- ☐ IUD ☐ Hormone Replacement Other Clinical History
- ☐ Radiation ☐ Systemic Chemotherapy ______
- ☐ Contraceptive Hormones ☐ HPV Vaccine ___/___ ______

ORDERING PROVIDER SIGNATURE

______

NON-GYN CYTOLOGY

☐ Routine ☐ Rapid M-F

CLINICAL INFORMATION & DIAGNOSIS

FINE NEEDLE ASPIRATION

- ☐ Breast, Right ☐ Breast Cyst, Right ☐ Thyroid, Right ☐ Thyroid Cyst, Right
- ☐ Breast, Left ☐ Breast Cyst, Left ☐ Thyroid, Left ☐ Thyroid Cyst, Left
- ☐ Other (specify location, cyst, or mass) ______

URINE CYTOLOGY ☐ Voided ☐ Catheterized Fix in CytoRich Red within 6 hours

OTHER ______

- ☐ Nipple Discharge, Right ☐ Nipple Discharge, Left
- ☐ Sputum ☐ Tzanck Prep
- ☐ Other ______

SURGICAL PATHOLOGY

- ☐ Microscopic examination ☐ Gross only examination
- ☐ Routine ☐ Rapid - call to number ______

CLINICAL INFORMATION & DIAGNOSIS

SURGICAL PROCEDURE

SPECIMEN SOURCE & LOCATION (SPECIFY LEFT OR RIGHT IF APPLICABLE)

SOURCE ON SPECIMEN VIAL MUST MATCH SOURCE ON REQUISITION

(1/13/22)