

WOMEN'S HEALTH REQUISITION

LAB
USE
ONLY

CLIENT INFORMATION *(Please check requesting physician)*

PATIENT INFORMATION *(Pink highlighted sections are required information)*

Please attach a patient face sheet and front and back of
primary and secondary insurance card:

PATIENT NAME REQUIRED

☐ See Attached

Name (Last, First): _____
Date of Birth: ____/____/____ Sex: M F SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Work Phone #: _____
Medical Record #: _____

BILLING INFORMATION

Primary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client
Insurance: _____ Policy # _____ Group #: _____
Ins. Address: _____ City: _____ State: _____ Zip: _____
Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

CLINICAL INFORMATION

Collection Date: _____

Clinical History: _____

I hereby authorize the release to EmeritusDX/Freedom of any medical and insurance information necessary to process
claims for services provided by EmeritusDX/Freedom. I hereby authorize EmeritusDX/Freedom to pursue all necessary
appeals of full or partial denials of payment in relation to services provided by EmeritusDX/Freedom.

Patient Signature _____

ICD-10 CODES *(Please check all that apply.)*

BLADDER/URINE

- ☐ **N39.0** Urinary Tract Infection
☐ **R31.0** Gross hematuria
☐ **R31.1** Benign microscopic hematuria
☐ **R31.9** Hematuria, unspecified
☐ **Z11.3** Screen for infections w/ sexual mode of
transmission
☐ **Z11.8** Screen for other infections
☐ **Other:** _____

PAP/MOLECULAR

- ☐ **Z12.4** Screen for malignant neoplasm
of cervix
☐ **Z01.419** Gyn exam (general/routine)
w/o abnormal findings
☐ **Z01.411** Gyn exam (general/routine) w/
abnormal findings
☐ **N76.0** Acute vaginitis
☐ **N94.6** Dysmenorrhea, unspecified
☐ **N87.9** Dysplasia of cervix uteri, unsp.
☐ **Z77.9** High Risk – Other contact with
(suspected) exposures to health
☐ **N92.6** Irregular menstruation, unsp.
☐ **D25.9** Leiomyoma of uterus, unsp.
☐ **B95.1** Positive for Group B Strep
☐ **B37.3** Positive for Vaginal Candidiasis
☐ **N95.0** Postmenopausal bleeding

- ☐ **Z39.2** Postpartum follow-up
☐ **Z11.51** Screen for human papillomavirus (HPV)
☐ **Z11.59** Screen for other viral diseases
☐ **Z12.72** Screen for malignant neoplasm of vagina
☐ **Z12.89** Screen for malignant neoplasm of other
sites
☐ **Other:** _____

PAP SMEAR – ROUTINE & MEDICARE SCREENING (ThinPrep Collection)

Medicare Screening PAP – Patient signed ABN required

Medicare covers screening Pap tests every 2 years for low-risk patients and annually for high-risk patients.

LMP (Required) ____/____/____

COLLECTION DEVICE:

☐ BROOM ☐ BRUSH ☐ Other: _____

SOURCE:

☐ Cervical ☐ Ecto/Endocervical ☐ Vaginal ☐ Other: _____

CLINICAL INFORMATION

- ☐ Postmenopausal ☐ Hysterectomy ☐ Ablation ☐ Postpartum
☐ Vaginal Discharge ☐ Oral Contraceptives ☐ DUB ☐ IUD
☐ Postmenopausal Bleeding ☐ Pregnant, Duration _____ wks
☐ Other: _____

TEST ORDER

- ☐ Pap, HPV* High Risk ☐ Pap, HPV* High Risk, CT/NG & Trichomonas
☐ Pap, HPV* High Risk & CT/NG *HPV, 14 High Risk genotypes. Reflex to 16 & 18/45 genotype if positive

BRUSHING/SWAB

COLLECTION METHOD

☐ Voided Urine ☐ Aptima® Swab

- ☐ **Aptima® Multitest**
☐ Bacterial vaginosis
☐ Candida species
☐ Candida glabrata

- ☐ Trichomonas vaginalis*
☐ Chlamydia & Gonorrhea (CT/NG)*
☐ Mycoplasma genitalium (M. gen)*

*May be ran on Voided Urine or Aptima® Swab

URINE/INFECTIOUS DISEASE TESTING

COLLECTION METHOD

☐ Voided Urine ☐ Catheterized

☐ STIDX™

TISSUE SPECIMENS SUBMITTED FOR PATHOLOGY EXAMINATION

ADDITIONAL TESTS/NOTES

Specimen #	Biopsy Site(s)	Comments
A	_____	_____
B	_____	_____
C	_____	_____

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or
treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested
hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

Physician/Authorized Signature _____ **Date** ____/____/____

Signature required on this order or in the patient's medical record

Please Discard Extra Labels

1-Complete all required information on requisition. 2-Use appropriate number of labels provided. 3-Place 1 label on each specimen container (not on lid).

NAME: _____	NAME: _____	NAME: _____	NAME: _____
DOB: _____	DOB: _____	DOB: _____	DOB: _____
DOS: _____	DOS: _____	DOS: _____	DOS: _____

ORGANISMS DETECTED

STIDX™

TRICHOMONAS VAGINALIS	NEISSERIA GONORRHOEAE	CHLAMYDIA TRACHOMATIS	GARDNERELLA VAGINALIS
HUMAN PAPILLOMAVIRUS TYPE 16	HUMAN PAPILLOMAVIRUS TYPE 18	HUMAN PAPILLOMAVIRUS TYPE 31	HUMAN PAPILLOMAVIRUS TYPE 33/52/67
TRICHOMONAS VAGINALIS	NEISSERIA GONORRHOEAE	CHLAMYDIA TRACHOMATIS	GARDNERELLA VAGINALIS

APTIMA® MULTITEST

BACTERIAL VAGINOSIS	CANDIDA GLABRATA	CANDIDA SPECIES	CHLAMYDIA TRACHOMATIS	MYCOPLASMA GENITALIUM
TRICHOMONAS VAGINALIS	NEISSERIA GONORRHOEAE			