

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 #: _____

CLINICAL INFORMATION

Collection Date: _____

Clinical History: _____

BILLING INFORMATION

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

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 SPATULA 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 Only
 - Pap, HPV High Risk*
 - Pap, Reflex HPV High Risk*
 - Pap, HPV High Risk* & CT/NG
 - Pap, Reflex HPV High Risk* & CT/NG
- *HPV High Risk – Reflex to 16 & 18/45 genotype if positive

BRUSHING/SWAB

COLLECTION METHOD

Voiced Urine Aptima® Swab

Aptima® Multitest

- Bacterial vaginosis
- Candida species
- Candida glabrata

Trichomonas vaginalis

- CT/NG C. trachomatis & N. gonorrhoea
- Mycoplasma genitalium (M. gen)

URINE/INFECTIOUS DISEASE TESTING

COLLECTION METHOD

Voiced Urine Catheterized Bladder Wash

UTIDX® (PCR Detection with AST)

UTIDX® and STIDX™

STIDX™ (Additional Specimen Tube Required)

Quantitative Urinalysis

TISSUE SPECIMENS SUBMITTED FOR PATHOLOGY EXAMINATION

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

ADDITIONAL TESTS/NOTES

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

UTIDX® ID, ABR, & AST

ACINETOBACTER BAUMANNII ACTINOBACULUM SCHAALII AEROCOCCUS URINAE ALLOSCARDOVIA OMNICOLENS CANDIDA ALBICANS	CANDIDA AURIS CANDIDA GLABRATA CANDIDA PARAPSILOSIS CITROBACTER FREUNDII CITROBACTER KOSER COAGULASE NEGATIVE STAPH CORYNEBACTERIUM RIEGELII	ENTEROBACTER AEROGENES ENTEROBACTER CLOACAE ENTEROCOCCUS FAECALIS ENTEROCOCCUS FAECIUM	ESCHERICHIA COLI KLEBSIELLA OXYTOCA KLEBSIELLA PNEUMONIAE MORGANELLA MORGANII MYCOPLASMA HOMINIS PANTOEA AGGLOMERANS	PROTEUS MIRABILIS PROTEUS VULGARIS PROVIDENCIA STUARTII PSEUDOMONAS AURUGINOSA SERRATIA MARCESCENS STAPHYLOCOCCUS AUREUS	STREPTOCOCCUS AGALACTIAE UREAPLASMA UREALYTICUM VIRIDANS GROUP STREP
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STIDX™

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

BACTERIAL VAGINOSIS GONORRHEA	CANDIDA GLABRATA	CHLAMYDIA	MYCOPLASMA GENITALIUM	CANDIDA SPECIES	TRICHOMONAS VAGINALIS
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