Emeritus MEDICAL TECHNOLOGY

☐ **EMERITUSDX**
12 SPECTRUM POINTE DR | LAKE FOREST, CA 92630
800-959-2846

☐ **FREEDOM PATHOLOGY PARTNERS**
524 EAST ELM STREET | CONSHOHOCKEN, PA 19428
800-959-2846

WOMEN'S HEALTH

CLIENT INFORMATION
PLEASE CHECK REQUESTING PHYSICIAN

CHECK ONE: ☐ TC ONLY ☐ GLOBAL ☐ CONSULTATION

PATIENT INFORMATION
(Pink highlighted sections are required information)

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

REQUIRED
Name (Last, First):______

Date of Birth: ___/___/___ Sex: M F SS#______

Address: ______

City: ______ State:____ Zip:______

Home Phone #: ______ Work Phone #: ______

Medical Record #: ______

BILLING INFORMATION
☐ *See Attached*

Primary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client

Insurance: ______ Policy #:______ Group #: ______

Ins. Address: ______ City: ______ State: ____ Zip: ______

Policy Holder: ______ DOB: ______

Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

CLINICAL INFORMATION

COLLECTION DATE:______/______/______

Clinical History: ______

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

Patient Signature: ______

ICD-10 CODES
Physician is required to (1) submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity, or (2) explain and have the patient sign an ABN.

Failure to provide ICD-10 code(s) will delay processing of the specimen. Listed below are commonly used ICD-10 codes, check codes that apply or list codes in the space provided to support the test request(s).

BLADDER/URINE
- ☐ N39.0 Urinary tract infection
- ☐ R31.0 Gross hematuria
- ☐ R31.1 Benign microscopic hematuria
- ☐ R31.9 Hematuria, unsp.
- ☐ C67.9 Malignant neoplasm bladder
- ☐ Z85.51 Personal hx malignant neoplasm, bladder
- ☐ Z11.3 Screen for infections w/ sexual mode of transmission
- ☐ Z11.8 Screen for other infections
- ☐ Other:______

PAP/MOLECULAR
- ☐ Z12.4 Screen for malignant neoplasmn of cervix
- ☐ Z01.419 Gyn exam (general)(routine) w/o abn finding
- ☐ Z01.411 Gyn exam (general)(routine) w/ abn finding
- ☐ N76.0 Acute vaginitis
- ☐ N94.6 Dysmenorrhea, unsp.
- ☐ 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

Medicare Screening PAP - Patient signed ABN required
Medicare will pay for a screening PAP every 2 years for early detection of cervical cancer on Low Risk patients, and every year for High Risk patients.

LMP (Required) _____/_____/_____

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
- ☐ Pap, HPV High Risk*, CT/NG & Trichomonas Vaginalis
- ☐ Pap, Reflex HPV High Risk*, CT/NG & Trichomonas Vaginalis

**HPV High Risk - Reflex to 16 & 18/45 genotype if positive*

ADD ON TEST ORDER
- ☐ CT/NG C. trachomatis & N. gonorrhoerae
- ☐ Trichomonas Vaginalis
- ☐ Bacterial Vaginosis
- ☐ Candida Vaginitis/Trichomonas Vaginalis
- ☐ Mycoplasma Genitalium
- ☐ Cervical FISH
- ☐ **COMPREHENSIVE FULL SCREEN** *(Test details on back)*

☐ **GYN Cytology High Risk (HR) Test** *(Test details on back)*
- 29 y.o and younger: Reflex on ASCUS & LSIL
- 30 y.o. and older: Reflex on +HPV HR or ASCUS & LSIL

BIOPSY & SITE

PREVIOUS PATHOLOGY DIAGNOSIS

Date of Dx: _____/_____/_____ **Diagnosis:**______

Biopsy: ☐ NOS ☐ CIN1 ☐ CIN2 ☐ CIN3/CIS
Pap Smear: ☐ WNL ☐ ASCUS ☐ LGSIL ☐ HGSIL
☐ HPV Pos ☐ Abn ☐ ASC-H ☐ Unsat

SITE
Endocervix ☐ ECC ☐ Brushing ☐ Biopsy ☐ Polypectomy
Cervix (site) A.______ B.______ C.______ D.______ E.______
Cone LEEP:______
Endometrium ☐ EMB ☐ EMC ☐ POC
Vaginal Bx:______ Vulva Bx:______ Perineum Bx:______
Other:______

IMMUNOHISTOCHEMISTRY (IHC)
☐ CD138 ☐ HPV ☐ Ki-67/p16 ☐ p53 ☐ ProExC ☐ Other: ______

COMPREHENSIVE PANEL: ☐ CD138, HPV, Ki-67/p16, p53, ProExC

HEMATURIA AND BLADDER CANCER

COLLECTION METHOD
☐ Voided Urine ☐ Bladder Wash ☐ Catheterized Urine ☐ Other:______

TEST ORDER
☐ Bladder FISH ☐ Bladder17™ ☐ ProExC ☐ Feulgen
☐ Urinalysis
☐ **Urinalysis Reflex:** Bladder FISH[1]
☐ Cytology
☐ **Cytology Reflex:** Bladder FISH[1]

[1]FISH reflex based on the presence of RBCs, urothelial cell lusters, atypia, suspicious or positive cytology
[2]Molecular UTI or Culture reflex based on the presence of leukocytes (LEU) or nitrates (NIT)

COMPREHENSIVE PANEL
☐ Urinalysis, Cytology, Bladder17, Bladder FISH, ProExC, Feulgen Stain

SYMPTOMATIC URINARY INFECTIONS

COLLECTION METHOD
☐ Voided Urine ☐ Catheterized Urine ☐ Other:______

☐ **UTIDX™ TEST** *(ID & Suscep if detected) Test details on back*
☐ **STIDX™ TEST**

BREAST CANCER

COLLECTION METHOD
☐ Rt Breast ☐ Lt Breast ☐ Other:______

TEST ORDER
IMMUNOHISTOCHEMISTRY: ☐ ER ☐ PR ☐ Her2 ☐ Ki-67 ☐ p53
FISH: ☐ Her2 by FISH
COMPREHENSIVE PANEL: ☐ ER, PR, Her2, Ki-67, p53

OTHER TESTS

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 the lid).

Any Questions?
Please Call Client Services
800-959-2846

Liquid Based Pap Name______	12 O'Clock Cerv. Bx Name______	6 O'Clock Cerv. Bx Name______	Cervical Cone Name______
ECC Name______	1 O'Clock Cerv. Bx Name______	7 O'Clock Cerv. Bx Name______	Cervical Swab Name______
Endomet Bx Name______	2 O'Clock Cerv. Bx Name______	8 O'Clock Cerv. Bx Name______	Rectal Swab Name______
Vaginal Bx Name______	3 O'Clock Cerv. Bx Name______	9 O'Clock Cerv. Bx Name______	Vaginal Swab Name______
Vulvar Bx Name______	4 O'Clock Cerv. Bx Name______	10 O'Clock Cerv. Bx Name______	Urine Name______
Lt. Labia Name______	5 O'Clock Cerv. Bx Name______	11 O'Clock Cerv. Bx Name______	______ Other Name______
Rt. Labia Name______	Ant. Leep Name______	Post Leep Name______	______ Other Name______

UTIDX™ UTI TEST ID, ABR & AST

Simple Cystitis, Interstitial Cystitis, Recurrent, Persistent, or Complicated UTI, and Prostatitis

- **Bacterial and Yeast Organisms** *Details listed below*
- **Bacterial Groups** *Details listed below*
- **Genotype Antibiotic Resistance Genes** *Details listed below*

UTIDX™ F-AST UTI TEST ID, ABR - 24 Hour TAT

Simple Cystitis, Interstitial Cystitis, Recurrent, Persistent, or Complicated UTI, and Prostatitis

- **Bacterial and Yeast Organisms** *Details listed below*
- **Bacterial Groups** *Details listed below*
- **Genotype Antibiotic Resistance Genes** *Details listed below*

ORGANISMS TESTED:

BACTERIAL AND YEAST ORGANISMS

- Acinetobacter baumannii
- Actinobaculum schaalii
- Aerococcus urinae
- Alloscardovia Omnicolens
- Candida albicans
- Candida auris
- Candida glabrata
- Candida parapsilosis
- Citrobacter freundii
- Citrobacter koseri
- 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 aeruginosa
- Serratia marcescens
- Staphylococcus aureus
- Streptococcus agalactiae
- Ureaplasma urealyticum
- Viridans Group Strep

GENOTYPE ANTIBIOTIC RESISTANCE GENES

- AMPICILLIN
- CARBAPENEM
- EXTENDED SPECTRUM BETA-LACTAMASE
- METHICILLIN
- QUINOLINONE/FLUOROQUINOLONE
- VANCOMYCIN

STIDX™

ORGANISMS TESTED

- Trichomonas Vaginalis
- Neisseria Gonorrhoeae-1
- Neisseria Gonorrhoeae-2
- BK Virus
- Chlamydia Trachomatis
- JC Virus
- Gardnerella Vaginalis
- Treponema pallidum (Syphilis)

GYN CYTOLOGY HIGH RISK (HR) TEST

- HPV High Risk
- p16/Ki-67
- Cervical FISH

COMPREHENSIVE FULL SCREEN

- CT/NG C. trachomatis & N. gonorrhoerae
- Trichomonas Vaginalis
- Bacterial Vaginosis
- Candida Vaginitis/Trichomonas Vaginalis
- Mycoplasma Genitalium
- Cervical FISH