QUALITY LABORATORY SERVICE
2818 OCEAN AVENUE • SUITE 5 • BROOKLYN, NY 11235
PHONE: 718-646-5100
FAX: 718-646-6300

Tissue Pathology Requisition

Patient Information or ▼ ADDRESSOGRAPH HERE ▼

Last Name | First Name | MI | M ☐ F ☐ | D.O.B.

Address (Street) | Apt # Floor Room#

City | State | Zip | Telephone #

Physician | Date Ordered

Care of/Guardian | Social Security # | Client Chart/Pt. ID#

Billing Information* ☐ Bill Medicare ☐ Bill Medicaid ☐ Bill Insurance ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Insurance Name | Insurance ID # | Group #/Category # | Insured Name (if different from patient)

Insurance Address | City | State | Zip | Telephone #

ICD9/Diagnosis Codes | Doctor's Signature

TYPE OF SPECIMEN

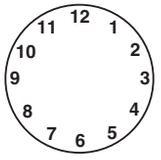
☐ RIGHT BREAST ☐ LFT BREAST ☐ POC ☐ VULVA ☐ VAGINA ☐ CERVIX ☐ ECC
☐ ENDOMETRIUM ☐ CURETTE ☐ PIPELLE ☐ STOMACH ☐ COLON ☐ ANUS ☐ SKIN
☐ ESOPHAGUS ☐ SMALL INTESTINE ☐ ORAL CAVITY ☐ BONE MARROW BX ☐ SCALP
☐ MARROW CLOT (FORMALIN) ☐ MARROW SMEAR ☐ PERIPHERAL SMEARS

LEFT PROSTATE - ☐ APEX ☐ MID ☐ BASE

RIGHT PROSTATE - ☐ APEX ☐ MID ☐ BASE

OTHER LOCATION _____

FOR COLPOSCOPY: CIRCLE LOCATION



COLPOSCOPY FINDINGS

NUMBER OF TISSUE FRAGMENTS SUBMITTED:_____ ☐ CHECK IF BIOPSY IS < THAN 1MM

☐ SHAVE BIOPSY ☐ PUNCH BIOPSY ☐ PARTIAL EXCISION ☐ CURATIVE EXCISION WITH MARGINS

SIMILAR LESIONS PRESENT: ☐ SOLARITY ☐ SEVERAL ☐ NUMEROUS

PREVIOUS BIOPSIES: SPECIMEN NO. / DATES:_____

PREVIOUS BIOPSIES AT SAME SITE; PREVIOUS DX:_____

G.I. SPECIMENS: ☐ BLEEDING ☐ PAIN

GYN SPECIMENS: ☐ LMP:_____/_____/_____ ☐ BLEEDING ☐ HORMONES:

PREVIOUS PAP DX: _____ PAP NO. _____

PERTINENT HISTORY: _____ CLINICAL DX:

MEDICARE INFORMATION

Medicare has established specific medical necessity requirements for laboratory tests. Government regulations require you to provide the laboratory with all applicable diagnosis codes for each test ordered. Medicare does not cover Screening Tests.

ADVANCE BENEFICIARY NOTICE (ABN)

To the Beneficiary:
Your physician may sometimes order laboratory testing that he or she believes to be necessary for your care, but which does not qualify for coverage under Medicare's standards. Medicare will only pay for services that it determines to be "reasonable and necessary" based upon the diagnosis information furnished to QLS by your physician. If, *under Medicare's standards,* your diagnosis does not support the testing ordered, Medicare will deny coverage. In those cases where Medicare denies coverage, the billing will be forwarded to you, and you will be responsible for the cost of the laboratory tests.

Beneficiary Agreement:
I have been notified by my physician/supplier that he or she believes that, in my case, Medicare may deny payment for the services identified above. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Medicare Patient - Screening Pap; routine *(reimbursement once every 3 years)*
Medicare Patient - Screening Pap; high risk of cervical cancer and physician recommends screening more often than every three years based on medical history.
Medicare Patient - Pap Smear; history of abnormality or signs or symptoms of medical necessity *(appropriate ICD-9 codes required)*

CRITERIA FOR HIGH RISK OF CERVICAL CANCER

1. Previous gynecological history of dysplasia or higher
2. HPV infection
3. HIV infection
4. Multiple sexual partners
5. Gross visible lesion
6. Early age of sexual intercourse
7. DES exposure
8. Smoker
9. Abnormal vaginal bleeding
10. Prior abnormal Pap smear or history of malignancy. (Please complete front of request form)

The Pap smear is not a diagnostic procedure and should not be used as the sole means to detect cervical cancer. It is only a screening procedure to aid in the detection of cervical cancer and its precursors. Both false-negative and false-positive results are known to occur.

TO ENSURE THE BEST POSSIBLE RESULT OF A PAP SMEAR, BE SURE THE PATIENT:

1. Abstains from sexual intercourse for 24-48 hours prior to the examination.
2. Abstains from using vaginal medication, vaginal contraceptives, or douches for 24-48 hours prior to the examination.
3. Is not having a menstrual period; if so, the appointment should be rescheduled, if possible.

THE OPTIMAL TIME FOR A PAP SMEAR IS AROUND DAY 16-18 OF THE MENSTRUAL CYCLE.