

**THE LAB OF PATH, P.A.**

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labofpath.com

REFERRING PHYSICIAN / CLINICIAN \_\_\_\_\_

COLLECTION DATA/TIME \_\_\_\_\_

PHONE / FAX \_\_\_\_\_

CLIENT NAME \_\_\_\_\_

**PLEASE PRINT**

**PATIENT INFORMATION**

PATIENT: \_\_\_\_\_  
LAST FIRST MI

BILL DOCTOR / CLINIC  BILL PATIENT / INSURANCE  
PATIENT INSURANCE: *PLEASE ATTACH COPY OF INSURANCE CARD OR PROVIDE INSURANCE COMPANY NAME, ADDRESS, & POLICY/ GROUP #. PLEASE LIST AS PRIMARY AND SECONDARY INSURANCE.*

ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

MEDICARE # \_\_\_\_\_  
MEDICAID # \_\_\_\_\_  
BLUE CROSS # \_\_\_\_\_

PHONE: \_\_\_\_\_ SEX:  M  F

OTHER INSURANCE / NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

ID: \_\_\_\_\_

GUARANTOR NAME: \_\_\_\_\_  
LAST FIRST MI

PATIENT RECORD ID #: \_\_\_\_\_

(ICD-9) / DX #: \_\_\_\_\_

**HISTOLOGY SPECIMEN INFORMATION**

- MARGINS  PUNCH 2-3-4-5-6-8  CURETTAGE  SCISSOR  SHAVE  EXCISION
- FLOW CYTOMETRY  CYTOGENETICS  OTHER \_\_\_\_\_

TISSUE SPECIMEN / BIOPSY SITE: \_\_\_\_\_

PRE-OP DIAGNOSIS (ICD-9) \_\_\_\_\_ POST-OP DIAGNOSIS \_\_\_\_\_

ACCESSION # / HISTORY: \_\_\_\_\_

PREVIOUS BIOPSY?  Y OR  N

**CYTOLOGY SPECIMEN INFORMATION**

- TYPE OF BODY CAVITY FLUID: \_\_\_\_\_
- FNA/CYST ASPIRATE SITE: \_\_\_\_\_
- SPUTUM  OTHER \_\_\_\_\_
- URINE, VOIDED OR CATHETERIZED (*please circle one*)  UROVYSION IF ABNORMAL  UROVYSION ONLY

HISTORY: \_\_\_\_\_

PREVIOUS PAP DATE: \_\_\_\_\_ LMP \_\_\_\_\_

RESULT \_\_\_\_\_ ACCESSION # \_\_\_\_\_

SITE:  CERVIX  VAG  ECC  OTHER \_\_\_\_\_

PREVIOUS BIOPSY?  YES ACCESSION # \_\_\_\_\_

- CHEMO OR RADIATION  MATURATION INDEX
- POST MENOPAUSAL  PREGNANT
- HYSTERECTOMY  POSTPARTUM
- HORMONES /  BCP'S  WELLNESS/ANNUAL
- HIGH RISK OF CERVICAL CANCER
- HISTORY OF ABNORMALITY OR SIGNS OR SYMPTOMS OF MEDICAL NECESSITY

**TEST(S) REQUESTED**

- ThinPrep® with Image
- Reflex HPV Typing (If Abnormal ThinPrep® Pap Diagnosis), for High Risk Strains only
- HPV Typing, for High Risk Strains only
- Chlamydia by Amplification
- Gonorrhea by Amplification
  - M-4 Swab
  - Urine Container
- Streptococcus, Group B by Amplification
- Herpes Simplex Virus 1 by Amplification
- Herpes Simplex Virus 2 by Amplification
- Wet Prep

Please consult with the patient regarding the accompanying  
Advance Beneficiary Notice (ABN).