CHI Health Laboratory
Creighton University Medical Center- Bergan Mercy
7500 Mercy Rd
Omaha, NE 68124
Phone: 402-717-5227 Fax: 402-717-5252

CHI Health
Imagine better health.SM

# Anatomical Pathology Requisition Completion

To ensure quality service it is imperative to complete the fields on the requisition completely and accurately.

**TOP HALF OF CHI HEALTH ANATOMICAL PATHOLOGY REF LAB REQUISITION**

1. **Patient's Legal Name**: Please print last name, first name, and middle Initial. Middle initial is imperative to ensure selection of the correct person.

2. **Patient's Social Security Number:** Needed if available for correct identification.

3. **Patient's Date of Birth**: Format acceptable is Month, Day, Year.

4. **Patient's Sex**: M or F Mark X in appropriate box.

5. **Patient Phone No.**: Phone no. will appear on the patient's lab report to aid physician contacting patient.

6. **Patient I.D.**: This field is for your clinic medical record/chart number and will print on report.

7. **Physician #1**: Print attending physician's last name, first name.

8. **Physician #2**: If another physician needs a copy of the report print physician's last name, first name.

9. **Date Collected**: Format is Month, Day, Year.

10. **Time Collected**: Use Military time (i.e. 0900, 1400) or (9:10 AM/ 3PM).

11. **Collected BY**: Print first Initial and full last name (i.e. S. Jones).

12. **Patient ICD10 CODE (Diagnosis**). Anatomical testing **MUST** have ICD10 codes provided in case there are professional fees. There is enough space to provide 3 ICD10 codes. Acceptable format is an alphanumeric coded diagnosis (i.e. V76.2). Narrative or descriptive codes will not be accepted. For surgical specimens the reason for the surgery should be listed.

**13 Bill to**: The client **MUST** identify Bill Type. Mark the appropriate box: Bill to Office Account or Bill to Patient/Insurance (refer to contract guidelines). Medicare/Medicaid and their products require testing to be billed by the performing lab.

**14 Pathology Bill:** Because of possible professional fee billing, insurance information **MUST** be filled out on all forms or a demographic sheet attached even if marked Bill to Office. A copy of the front and back of the insurance card is required. CHI Health Clinic Pathology, our pathology group, will always bill patient or insurance for the technical/professional part of histology testing.

**15 Guarantor/Responsible Party:** Indicate the Guarantor/Responsible party and the phone number and address of the responsible party.

**16 Insurance Information Required:**

- PRIMARY Insurance: Name of Insurance Company
  Policy #:
  Group #:

  Address of Payer
- SECONDARY Insurance: Name of Insurance Company
  Policy #:
  Group #:

  Address of Payer

**17 PAP:** Mark one box. Select "Screening PAP Test" for those PAPS that have no diagnostic reason except screening. Follow Medicare/Medicaid rules for a required ABN if sooner than allowed. Select "Diagnostic PAP Test" for all PAPS that have signs or symptoms of disease.

**THE BOTTOM HALF OF THE CHI HEALTH LABORATORY ANATOMICAL PATHOLOGY REQUISITION:**

18 The bottom half of the Anatomic Pathology Lab Requisition is separated into three sections.

**19 Gynecological tests:** please fill out the GYN (PAP) Cytology section.

- Indicate the source of specimen. (Cervical, Vaginal, Endocervical) Required for report completion!
- Check whether the specimen is a smeared slide or a thin-prep fluid.

- Provide the date of the patient's last menstrual Period.
- Provide as much clinical information as possible.
- Record the date and diagnosis of the patient's last Pap Smear.
- Include any other pertinent clinical information in the Dr. Comments area.
- GC and Chlamydia boxes on new requisitions are available for Molecular Testing.
- Add HPV if you wish testing done not matter if normal. We reflex high ascus automatically.

20 **Non-Gyn Cytology Fluids:** select the appropriate specimen source.
- If Fine Needle is selected, be sure to include the specimen site.
- Designate whether the patient is on radiation therapy.
- Include any pertinent clinical history.

21 **Histology/Tissue Specimens:** designate the source of the specimen and anatomical site. If more than one tissue specimen is submitted designate so on the lines provided.
- Record the Pre-op diagnosis.
- Record the patient's clinical history.
- Record the Post-op diagnosis if applicable.

21 **Medicare Limited Coverage Test** requests must be accompanied by a waiver (Advanced Beneficiary Notice) signed by the patient PRIOR to the collection of the specimen. Please acknowledge whether a waiver has been signed by marking the appropriate box. Attach the waiver to the requisition.

22 **Marital Status:** Mark appropriate box.

23 **Web Page:** Refer to our Reference Lab Guide on web page **www.chihealth.com/lab-services** for instructions on proper handling of specimens, including approved lubricants for ThinPrep paps and transport
temperature.

24 **Specimen Labeling:** We require on all specimens permanent identifiers of ***Patient's Last Name, First Name, Date of Birth, Collection Date and Time, and Initials of Collector.***

25 **Call/Fax**: If lab results are to be called or faxed, write on requisition the name of fax/phone recipient, and secure fax/phone number.

CHI Health
Imagine better health.℠

**CUMC-Bergan Mercy Laboratory**
7500 Mercy Rd
Omaha, NE 68124
Phone: (402) 717-5227
Fax: (402) 717-5252

Client Code:

| LAB USE ONLY |
|---|
| Date Received: |
| Number of Slides: |
| Accession Number: |
| Accession Number: |
| Account Number: |
| SMS Admit Number: |

## PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION REQUIRED FOR ALL TESTING

| (Legal Name) Last | First | MI | DOB | SSN | ☐ Male ☐ Female | Phone Number |
|---|---|---|---|---|---|---|

| Patient ID | Physician #1 First & Last Name | Physician #2 First & Last Name | Date Collected | Time Collected |
|---|---|---|---|---|

**REQUIRED:** Indicate Appropriate ICD10 Numeric Code(s) in Box(es) Below

ICD10 1. 2. 3.

CHECK ONE:
☐ **Bill to Office Account**
☐ **Bill to Patient / Insurance**
**(MUST complete information below or attach registration sheet for ALL patients.)**

**MEDIPASS AUTHORIZATION NUMBER**

**Numeric code must be given for all PAP testing to be billed to the patient or patient's insurance. If information is not complete, the form and specimen will be returned for completion prior to testing.**

☐ **SCREENING PAP TEST**
No signs or symptoms of disease. Strictly preventive in nature.
Medicare Patients: See waiver section below and sign as appropriate.

☐ **DIAGNOSTIC PAP TEST**
There are (or have been) signs or symptoms of disease. Appropriate ICD10 numeric code is written above.

| Guarantor / Responsible Party | **Primary Insurance** | **Secondary Insurance Name** |
|---|---|---|
| Phone Number of Guarantor | Policy Number | Policy Number |
| Address | Group Number | Group Number |
| City, State, Zip | Address of Payer | Address of Payer |

## GYN (PAP) CYTOLOGY

**SOURCE OF SPECIMEN**
☐ Cervical / Endocervical
☐ Vaginal

**SPECIMEN SUBMITTED**
☐ Smeared Slide
(Label slide with patient name and DOB in pencil.)
☐ Liquid-Based PAP Test
(Label container with patient name and DOB.)

Clinical Data: LMP: Date:

☐ Biopsy also sent ☐ Menopause ☐ Colpo ☐ Chemo
☐ B.C. Pill ☐ Hysterectomy ☐ Laser ☐ Radiation
☐ I.U.D. ☐ Hormone Rx. ☐ Cryo ☐ Other
☐ Pregnant ☐ Abnormal bleeding ☐ Cone / Leep / Leitz
☐ Post-Partum
☐ Breast Feeding

**Previous PAP:** Date: Result:

**Dr. Comments:**

☐ HPV ☐ Chlamydia ☐ GC

## NON-GYN CYTOLOGY / FLUID

**SOURCE OF SPECIMEN**
☐ Sputum
☐ Bronch-Wash
☐ Bronch-Brush
☐ Bal
☐ Fine Needle Aspiration
Organ Site:
☐ Other Specimen:

☐ Gastric
☐ Esophageal
☐ Breast Fluid R or L
☐ CSF
☐ Urine
☐ Ovarian Fluid R or L
☐ Pleural Fluid R or L
☐ Perit Fluid
☐ Cul-De-Sac Fluid
☐ Pericard Fluid

**Clinical History:**

## HISTOLOGY / TISSUE

**TISSUE SPECIMEN AND SITE: LIST ALL**
☐ Single Biopsy / Source:
☐ Biopsy / Multiple (State Source Each Specimen Below)

A.
B.
C.
D.
E.

Pre-Op Diagnosis

History (Pertinent Clinical History)

Post-Op Diagnosis:

Formalin Added Time

When asterisked tests are ordered on Medicare patients they are likely to be denied by Medicare unless medical necessity is established.
Consult reference guide and have patient sign waiver, if appropriate.
*Medicare limited coverage test. Medicare may not pay for this service or this

**ABN waiver signed and attached:** ☐ **Yes** ☐ **No**