PHYSICIANS LABORATORY, P.C.

4840 “F” STREET • OMAHA, NE 68117 • (402) 731-4145 • FAX (402) 731-8653 • 800-642-1117
7441 “O” STREET, SUITE 100 • LINCOLN, NE 68510 • (402) 488-7710 • FAX (402) 488-6941

PLEASE PRINT

PATIENT LAST NAME | FIRST | MI | PATIENT PHONE NUMBER

PATIENT ID / CHART NO.

DATE OF BIRTH / / SEX

SPECIMEN DATE

TIME DRAWN A.M. P.M.

FASTING YES ☐ NO ☐

COMPLETION OF THIS SECTION AUTHORIZES PHYSICIANS LABORATORY TO BILL THE PATIENT DIRECTLY OR THE FOLLOWING INSURANCE CO.

☐ MEDICARE ☐ MEDICAID

INSURER ______

ID NO. ______

GROUP NO. ______

☐ INSURANCE INFORMATION ATTACHED

PATIENT ADDRESS

CITY

ST ZIP CODE

MEDICARE WAIVER SIGNED ☐ YES ☐ NO

BILL TO: ☐ Client Account ☐ INSURANCE: List info above & DX code ☐ PATIENT: List address above & DX code

Physician ______
FIRST & LAST NAME

ICD 10 / DX:

TISSUE SPECIMEN(S)

SOURCE OF SPECIMEN(S):

A: ______

B: ______

C: ______

D: ______

PROCEDURE(S) PERFORMED

______

______

CLINICAL / HISTORY

(Please attach OP Note & H&P)

______

______

______

GYNECOLOGIC SPECIMENS

Date of LMP: ______ ☐ Post Menopausal

☐ Contraceptive / IUD: ______ (Type)

Hormone Therapy:
☐ Estrogen ☐ Progesterone ☐ None

Abnormal Bleeding?
☐ Yes ☐ No

Previous Pap(s) / Biopsy(s):

______

ICD 10 / DX:

PAP SMEAR / HPV

SOURCE OF SPECIMEN:

☐ Cervix ☐ Vagina ☐ Endocervix

☐ Other ______

CLINICAL / HISTORY

Date of LMP: ______ ☐ Post Menopausal

☐ Contraceptive / IUD: ______ (Type)

Hormone Therapy:
☐ Estrogen ☐ Progesterone ☐ None

Abnormal Bleeding?
☐ Yes ☐ No

Previous Pap(s) / Biopsy(s):

______

PAP TESTING w/AUTO REFLEX PER ACOG GUIDELINES

☐ 3615 Pap, ThinPrep® Image w/ Reflex to HPV (ACOG)
☐ 3616 Pap, ThinPrep® w/ Reflex to HPV (ACOG)

PAP TEST ONLY

☐ 3515 Pap, ThinPrep® Computer Imaging
☐ 3516 Pap, ThinPrep®
☐ 3417 Pap, Conventional

HPV TEST ONLY

☐ 7613 HPV High Risk Only
☐ 7614 HPV High Risk w/Reflex to 16/18 Genotype

OTHER TESTING

☐ 2082 Chlamydia/GC Liquid Based Vial
☐ 1987 Trichomonas Liquid Based Vial
☐ 2000 Chlamydia/GC/Trich Liquid Based Vial

ICD 10 / DX:

NON-GYN CYTOLOGY

SOURCE OF SPECIMEN(S):

☐ Breast Secretion
☐ Left ☐ Right

☐ Bronchial Brushing
☐ Left ☐ Right

☐ Bronchial Washing
☐ Left ☐ Right

☐ CSF

☐ Peritoneal Fluid

☐ Pleural Fluid
☐ Left ☐ Right

☐ Sputum

☐ Synovial Fluid
Source ______

☐ Urine
☐ Voided ☐ Cath ☐ Cysto

☐ Fine Needle Aspiration
Source ______

☐ Tzank (Prep for Herpes)

☐ Misc Fluid or Smear
Source ______

CLINICAL / HISTORY

______

______

______

FOR INTERNAL USE ONLY

Test	CPT	Test	CPT	Test	CPT	Test	CPT
______	88300 ___	______	88305 ___	______	88311 ___	______	88331 ___
______	88302 ___	______	88307 ___	______	88312 ___	______	88332 ___
______	88304 ___	______	88309 ___	______	88313 ___	______	88342 ___