Spectrum Health Regional Laboratories
Anatomic Pathology (Patient Bill)

SPECTRUM HEALTH

ID: _____ Office: _____

Address: _____

Phone: _____ Fax: _____

Provider Name: _____
PRINT First and Last Name. No Initials.

NPI *(optional)*:_____

Provider Signature: _____

Date ordered	Date collected	Time collected	Collector

Patient Information - REQUIRED

Name Last First MI

Address | Phone

City State Zip

Sex | Marital Status | Birth date | Cell Phone

Billing - REQUIRED

Attach a copy of face sheet and insurance card. Specimen will be registered as patient self-pay and bill be the responsibility of the patient if information is not provided.

Bill to:

Patient or Insurance Name_____

Policy Number_____

Note: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. Be certain the patient has signed the Advanced Beneficiary Notice (ABN) CMS-R 131 as needed.

Additional Reports to

Name Fax

Name Fax

Diagnosis Code(s) - REQUIRED

1.
2.
3.

CLINICAL INFORMATION FOR HISTOLOGY AND CYTOLOGY

Pertinent Clinical Information/Reason for Exam
(examples: history of malignancy, pertinent laboratory studies, radiology studies)

Required for breast tissue only
Cold ischemia start time
Formalin fixation START time
Total cold ischemia time
Formalin fixation STOP time
Total formalin fixation time

MEDICAL CYTOLOGY FLUID COLLECTION

❍Peritoneal Fluid
❍Pleural Fluid ❍Right ❍Left
❍Cerebrospinal Fluid (CSF)
❍Bronchial Washing ❍Right ❍Left
❍Bronchial Lavage ❍Right ❍Left
❍Bronchial Brushing ❍Right ❍Left
❍Sputum
❍Cyst Fluid, Source: _____
❍Urine, Voided
❍Urine, Catheterized
❍Bladder Washing
❍Renal Pelvic Fluid/Washing ❍Right ❍Left
❍Esophageal brushing
❍Nipple Secretion ❍Right ❍Left
❍Other (specify): _____

FINE NEEDLE ASPIRATION

❍Breast ❍Right ❍Left
❍Wang Needle Aspirate, Specify site:_____
❍Thyroid ❍Right ❍Left ❍Isthmus
❍Lymph Node, Specify site: _____
❍Salivary Gland, Specify site: _____
❍Skin/Subcutaneous, Specify site: _____
❍Other (specify): _____

GYNECOLOGICAL COLLECTION (Mandatory for PAP and GYN Biopsy)

LMP:_____ Previous PAP (date):_____ Abnormal PAP (date):_____ Pregnant (# of weeks):_____ Post-partum (# of weeks):_____

Menopause (yrs):_____ Hyst-Subtotal (has cervix):_____ Hyst-Total (cervix removed):_____ Hormone Therapy: ❍No ❍Yes, specify _____

PAP/HPV Testing (Type, Source and Reflex information required)

❍**Pap Test** ❍ Screening ❍ Diagnostic
Source: ❍ Cervix ❍ Vaginal
HPV reflex? ❍ No HPV ❍ Co-Testing (30-64 y/o) ❍ Reflex

Refer to SpectrumHealth.TestCatalog.org for reflex details

STD Testing(please indicate specimen source)

❍ Chlamydia PCR *(Abbott)* _____ ❍Chlamydia NAAT-APTIMA _____
❍ Chlamydia/GC PCR *(Abbott)*_____ ❍Chlamydia/GC NAAT-APTIMA_____
❍ Gonococcus (GC) PCR *(Abbott)*_____ ❍Gonococcus (GC) NAAT-APTIMA_____
❍ Herpes Simplex PCR for Lesions_____ ❍Trichomonas NAAT-APTIMA_____

COLLECTION FOR TISSUE PATHOLOGY **Preservative** TISSUE(S) REMOVED (Please no abbreviations)	COLLECTION FOR TISSUE PATHOLOGY – FRESH **No Preservative** TISSUE(S) REMOVED (Please no abbreviations
A	A
B	B
C	C
D	D
E	E
❍Consultation (indicate specimen source and attach previous reports if indicated):	_____

DERMATOPATHOLOGY

	Site	Location	Check	Clinical Diagnosis/Prior Pathology	Clinical Description of Lesion(s)	Size of Lesion(s)
A		❍Left ❍Right	❍Excision ❍Shave ❍Punch ❍Curette ❍Biopsy ❍Re-Excision			
B		❍Left ❍Right	❍Excision ❍Shave ❍Punch ❍Curette ❍Biopsy ❍Re-Excision			
C		❍Left ❍Right	❍Excision ❍Shave ❍Punch ❍Curette ❍Biopsy ❍Re-Excision			
D		❍Left ❍Right	❍Excision ❍Shave ❍Punch ❍Curette ❍Biopsy ❍Re-Excision			