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# Pathology Requisition

## Marlboro-Chesterfield Pathology, P.C.

• Surgical Pathology • Cytology • Molecular Pathology

PRXXXXXXX

### PATIENT INFORMATION

Last Name | First Name | M.I.

Street Address | Apt. #

City | State | Zip Code

Phone | Birth Date / / | Age | Sex

Chart # | Social Security #

### BILLING INFORMATION (Please check one)

☐ Included Copy of Insurance Card ☐ Self Pay ☐ Bill Account ☐ Other ______

### CLINICAL INFORMATION (Please complete)

Collection Date / / | Collection Time : (Required for Breast Pathology) | Initials | Accession # (Lab use only)

Preoperative Diagnosis ______

Postoperative Diagnosis ______

### ACCOUNT INFORMATION

PROOF

Requesting Physician: ______

Referring Physician: ______

Referring Physician Fax #: ______

### CLINICAL HISTORY

### GYN CYTOLOGY (Please check all that apply)

LMP

☐ Routine Exam
☐ Repeat PAP
☐ Pregnant (wks____)
☐ Post-Partum (wks____)
☐ Postmenopausal (yr____)

☐ Total Hysterectomy
☐ Supracervical Hysterectomy
☐ Prior HPV Positive
☐ Uterine Fibroids
☐ History of Radiation
☐ Hormone (current use)

☐ Depo Provera
☐ Oral Contraceptives
☐ History of Dysplasia
☐ Previous GYN Malignancy
☐ Abnormal Bleeding
☐ Other______

**Check specimen source and test requested (required)**

**Specimen Source:** ☐ Endocervix/Exocervix ☐ Vaginal

**Gyn Tests:** ☐ ThinPrep ☐ SurePath ☐ Conventional/Slide ☐ Aptima

**HPV Tests:** ☐ Pap with HPV ages 30 and over
☐ Reflex to HPV if ASCUS or higher
☐ HPV Only ☐ No HPV

**Molecular Tests:** ☐ Chlamydia & N. Gonorrhea ☐ Chlamydia Only ☐ N. Gonorrhea Only

### NON-GYN CYTOLOGY (Please check appropriate site)

☐ Bladder Wash ☐ Bronchial Brushing ☐ Esophageal Brushing ☐ Pleural Fluid ☐ Urine Voided ☐ Thyroid ☐ Other (please specify) ______
☐ Breast (left or right) ☐ Bronchial Wash ☐ Peritoneal Fluid ☐ Sputum ☐ Urine Cath

### SURGICAL PATHOLOGY (TISSUE SUBMITTED: List Specimen Source)

Jar #1 ______ Jar #4 ______ Jar #7 ______

Jar #2 ______ Jar #5 ______ Jar #8 ______

Jar #3 ______ Jar #6 ______ Jar #9 ______

***I Accept Responsibility for All Charges Not Covered by Medicare, Medicaid, or Insurance Companies.*** Patient Signature ______

| Jar #1 PRXXXXXXX<br>Site/Type ______<br>Patient ______ | Jar #4 PRXXXXXXX<br>Site/Type ______<br>Patient ______ | Jar #7 PRXXXXXXX<br>Site/Type ______<br>Patient ______ |
|---|---|---|
| Jar #2 PRXXXXXXX<br>Site/Type ______<br>Patient ______ | Jar #5 PRXXXXXXX<br>Site/Type ______<br>Patient ______ | Jar #8 PRXXXXXXX<br>Site/Type ______<br>Patient ______ |
| Jar #3 PRXXXXXXX<br>Site/Type ______<br>Patient ______ | Jar #6 PRXXXXXXX<br>Site/Type ______<br>Patient ______ | Jar #9 PRXXXXXXX<br>Site/Type ______<br>Patient ______ |

*30 Page Street • Pinehurst, NC 28374 • Phone: 910.687.4188 • Fax: 910.235.0171*

**WHITE COPY to Marlboro-Chesterfield Pathology, P.C. / PINK COPY to Physician** / CLIA number: 42D0713042 CAP: 1426105 / © 2011 Marlboro-Chesterfield Pathology, P.C. Form PR-101 / 9.20.11

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PROOF 2

8210163386

FACE PARTS 1; PERF AS SHOWN; SCREEN 10%; LABEL AS SHOWN

FP

PROOF

LINER AREA

8210163386

BACKER PART1; LINER AS SHOWN

2A

1B

# Pathology Requisition

**Marlboro-Chesterfield Pathology, P.C.**

• Surgical Pathology • Cytology • Molecular Pathology

PRXXXXXXX

2A

1B

## PATIENT INFORMATION

| Last Name | First Name | M.I. |
|---|---|---|
| Street Address | | Apt. # |
| City | State | Zip Code |
| Phone | Birth Date / / | Age | Sex |
| Chart # | Social Security # | |

## ACCOUNT INFORMATION

PROOF

**Requesting Physician:** ____________________

**Referring Physician:** ____________________

**Referring Physician Fax #:** ____________________

## BILLING INFORMATION *(Please check one)*

☐ Included Copy of Insurance Card ☐ Self Pay ☐ Bill Account ☐ Other ____________

## CLINICAL INFORMATION *(Please complete)*

| Collection Date / / | Collection Time : (Required for Breast Pathology) | Initials | Accession # (Lab use only) |
|---|---|---|---|

Preoperative Diagnosis ____________________

____________________

Postoperative Diagnosis ____________________

____________________

## CLINICAL HISTORY

## GYN CYTOLOGY *(Please check all that apply)*

LMP

| | | |
|---|---|---|
| | ☐ Total Hysterectomy | ☐ Depo Provera |
| ☐ Routine Exam | ☐ Supracervical Hysterectomy | ☐ Oral Contraceptives |
| ☐ Repeat PAP | ☐ Prior HPV Positive | ☐ History of Dysplasia |
| ☐ Pregnant (wks____) | ☐ Uterine Fibroids | ☐ Previous GYN Malignancy |
| ☐ Post-Partum (wks____) | ☐ History of Radiation | ☐ Abnormal Bleeding |
| ☐ Postmenopausal (yr______) | ☐ Hormone (current use) | ☐ Other________ |

### *Check specimen source and test requested (required)*

**Specimen Source:** ☐ Endocervix/Exocervix ☐ Vaginal

**Gyn Tests:** ☐ ThinPrep ☐ SurePath ☐ Conventional/Slide ☐ Aptima

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**Molecular Tests:** ☐ Chlamydia & N. Gonorrhea ☐ Chlamydia Only ☐ N. Gonorrhea Only

## NON-GYN CYTOLOGY *(Please check appropriate site)*

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Bladder Wash | ☐ Bronchial Brushing | ☐ Esophageal Brushing | ☐ Pleural Fluid | ☐ Urine Voided | ☐ Thyroid | ☐ Other (please specify) ____________ |
| ☐ Breast (left or right) | ☐ Bronchial Wash | ☐ Peritoneal Fluid | ☐ Sputum | ☐ Urine Cath | | ____________ |

## SURGICAL PATHOLOGY *(TISSUE SUBMITTED: List Specimen Source)*

| | | |
|---|---|---|
| Jar #1 ________ | Jar #4 ________ | Jar #7 ________ |
| Jar #2 ________ | Jar #5 ________ | Jar #8 ________ |
| Jar #3 ________ | Jar #6 ________ | Jar #9 ________ |

***I Accept Responsibility for All Charges Not Covered by Medicare, Medicaid, or Insurance Companies.*** Patient Signature ____________________

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FACE PART 2; PERF AS SHOWN; SCREEN 10%