ANATOMIC PATHOLOGY OUTPATIENT SERVICES

GRAND TRAVERSE PATHOLOGY PLLC

MUNSON MEDICAL CENTER, TRAVERSE CITY, MI 49684
MERCY HOSPITAL CADILLAC, CADILLAC, MI 49601
MERCY HOSPITAL GRAYLING, GRAYLING, MI 49738

PATIENT LEGAL NAME - LAST | FIRST | MIDDLE INIT | SEX

MARITAL STATUS S / M / D / W / X | PREVIOUS LAST NAME (if applicable)

ADDRESS | CITY | STATE | ZIP

BIRTH DATE | SOC. SEC. NO. | PATIENT PHONE NUMBER

GUARANTOR NAME - RESPONSIBLE FOR PAYMENT (fill in only if different from patient's) | LAST / FIRST / MI / BIRTH DATE

GUARANTOR ADDRESS | CITY | STATE | ZIP | TELEPHONE NUMBER

INSURANCE INFORMATION: Please fill out below or attach copy of insurance card(s).

Primary Insurance: ❒ Medicare ❒ Medicaid ❒ BC/BS ❒ Other _____

SUBSCRIBER # | GROUP #

SUBSCRIBER NAME | RELATIONSHIP

Secondary Insurance: ❒ Medicare ❒ Medicaid ❒ BC/BS ❒ Other _____

SUBSCRIBER # | GROUP #

SUBSCRIBER NAME | RELATIONSHIP

CLINICAL HISTORY / PRE-OP DIAGNOSIS

_____ _____
PHYSICIAN SIGNATURE DATE

COPY OF REPORT TO: _____

DO NOT WRITE IN THIS SPACE

Medical Record No:_____

Pap Number:_____

BAR CODE LABEL

COLLECT DATE | DATE RECEIVED

TISSUE SUBMITTED:

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

CYTOPATHOLOGY - Non-Gynecologic

Specimen Site: _____ ❑ **Right** ❑ **Left**

Diagnosis/Code/Narrative: _____

- ❑ Urine, Voided
- ❑ Urine, Catheter
- ❑ Urine, Cytoscopy
- ❑ Bladder Washing
- ❑ Bronchial: *Site*: _____
  - ❑ Brushing ❑ Washing
  - ❑ BAL ❑ Wang Needle
- ❑ Pericardial Fluid
- ❑ Peritoneal Fluid
- ❑ Pleural Fluid
- ❑ Pelvic Washing
- ❑ Anal Pap
- ❑ Fine Needle Aspirate
- ❑ Sputum
- ❑ Esophogeal Brushing
- ❑ Cerebrospinal Fluid
- ❑ Nipple Discharge
- ❑ Other Specimen
  Specify: _____

CYTOPATHOLOGY - Gynecologic

Specimen Type: ❑ Cervical ❑ Endocervical ❑ Vaginal ❑ Other: _____

Diagnosis/Code/Narrative: _____

TEST: ❑ **Screening Pap** Dx: Screening (Z124) Frequency ABN required for Medicare patients.

❑ **Diagnostic Pap** Patient has had previous abnormal tests or findings, symptoms, or significant complaints. Dx:_____

❑ **High Risk HPV Test** *(Thin Prep or Digene Transport Swab):*

❑ If ASCUS ❑ Regardless of Results
❑ If Negative ❑ All Atypical / Abnormal Results

Diagnosis for HPV: ❑ Screening (Z1151)
❑ Other: _____

❑ **Anal/Rectal High Risk HPV** *(Digene Transport Swab only)*

*****RELEVANT HISTORY - Testing will be delayed if not provided *****

LMP: _____ ❑ **LMP Unavailable** *(For women less than 50, a LMP or reasonable estimate is required)*

- ❑ Pregnant: **Weeks:**_____
- ❑ Previous Abnormal Pap
- ❑ Hormonal Therapy
- ❑ IUD In Place
- ❑ Postmenopausal
- ❑ Postpartum: **Weeks:**_____
- ❑ Abnormal Cervix
- ❑ Hysterectomy
- ❑ Supracervical Hysterectomy
- ❑ Chemotherapy/Radiation
- ❑ GYN Complaint: _____
- ❑ Previous GYN Cancer: _____
- ❑ Previous GYN Surgery: _____
- ❑ Significant Non-GYN Disease/Abnormality: _____