VCU Medical Center
VIRGINIA COMMONWEALTH UNIVERSITY

OUTREACH REQUISITION

Phone: 804-828-7284
Fax: 804-628-8724

VCU Department of Pathology

CYTOPATHOLOGY CLAB

ACCOUNT INFORMATION

Physician:

PLEASE SEND COPY TO FACILITY: _____

PHYSICIAN: _____

Last Name: _____ MI: _____

First: _____

DOB: ___/___/___ SSN: _____ MRN: _____

Gender: ☐ Male ☐ Female RACE: ☐ Black ☐ White ☐ Other

Address: _____

Ciy: _____ State: _____ Zip: _____

Phone No: (_____)_____- _____

Insurance Co Name: _____

Address: _____

Subscriber No: _____ Group No: _____

Subscriber No: ☐ SELF ☐ SPOUSE ☐ OTHER ☐ Policy Holder _____

Medicare No: _____ ☐ Primary ☐ Secondary

Medicaid No: _____

FOR OUTPATIENTS ONLY: is there a planned hospital admission within the next three days? ☐ NO ☐ YES If Yes, Provide Name of Hospital: _____ ☐ INPATIENT ☐ OUTPATIENT

Specimen Collection Date: _____ Collection Time: _____ ☐ AM ☐ PM Initials: _____

Non-Gynecological Services	DX CODE
☐ Body Cavity / Fluid Washing	
☐ CSF	
☐ Fine Needle Aspiration: Source _____	
☐ Other (Specify) _____	
Respiratory Cytology	
☐ Bronchial Brushing	
☐ Bronchial Washing	
☐ Bronchoalveolar Lavage (BAL)	
☐ Sputum Cytology	
Urinary Cytology	
☐ Bladder Washing	
☐ Urethral Cytology	
☐ Urine, Catheterized	
☐ Urine, Voided	
Gynecological Cytology Services	DX CODE
Check Ordered Test (Co-Collection Pap & STM Tube)	
☐ 4100 Pap Test Requested (only) SCREENING	
☐ 4100 Pap Test Requested (only) DIAGNOSTIC	
☐ 4101 Pap Test w/Reflex HPV SCREENING	
☐ 4101 Pap Test w/Reflex HPV DIAGNOSTIC	
☐ 4102 Pap Test & HPV SCREENING	
☐ 4102 Pap Test & HPV DIAGNOSTIC	
☐ 4103 Human Papilloma Virus Detection (only)	

Date of LMP _____ / _____ / _____

Check Collection Method

☐ Liquid based Pap **(SurePath Blue Cap Vial)**
☐ Pap Smear / Slide # of Slides _____

Check Specimen Source

☐ Cervical ☐ Cervical/Vaginal
☐ Vaginal ☐ Vaginal Cuff

Clinical History

☐ No significant clinical history
☐ Hysterectomy, supracervical
☐ Hysterectomy, total
☐ Postmenopausal
☐ Postpartum
☐ LEEP
☐ Abnormal bleeding
☐ DES Exposure
☐ Other _____
☐ Hx of Herpes
☐ IUD
☐ Pregnant
☐ Radiotherapy
☐ Chemotherapy
☐ Tamoxifen
☐ Estrogen replacement therapy
☐ OCP

High Risk Factors

☐ None
☐ HIV +
☐ Other _____
☐ HPV +
☐ Abnormal Pap

History of Cancer

☐ None
☐ Cervical (squamous cell carcinoma)
☐ Endocervical (adenocarcinoma)
☐ Endometrial
☐ Breast
☐ Ovarian
☐ Lymphoma
☐ Melanoma
☐ Lung
☐ Colon
☐ Bladder
☐ Other _____

All shaded area information must be completed. Complete all pertinent clinical information and history with sample submission.

MEDICARE ADVANCE BENEFICIARY NOTICE - SCREENING PAP SMEARS

Because the screening Pap Smear is a Medicare Frequency - Limited Service the ABN may be used routinely by having the Medicare Beneficiary Sign either of the two applicable agreements shown below. Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare programs, Medicare will deny payment for a ***Screening Pap Smear if you have had one during the last three (3) years.***

BENEFICIARY AGREEMENT: "I have been notified by my ***physician/laboratory*** that Medicare will deny payment for a ***Screening Pap Smear if I have had one during the last three (3) years.*** I believe that I have not had / have had *(CIRCLE ONE)* a ***Screening Pap Smear during the last three (3) years.*** If I am mistaken and Medicare denies payment, I agree to be personally and fully responsible for payment.

_____

Beneficiary Signature