2832 JUNIPER STREET • FAIRFAX, VA 22031

Specimen Pickup - Lab Results (703) 645-6175

Date Collected:	Time Collected:	Collected By:	Time in Formalin (Required for Breast)	# of Specimen Containers

ICD ________ ICD ________ ICD ________

STAT ☐ **BILL:** ☐ OFFICE ☐ PAT. INSURANCE ☐ PATIENT

ATTACH INSURANCE CARDS

PATIENT LAST NAME	FIRST NAME	MI

SEX (M-Male F-Female)	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY #	PHONE	PHONE (Other)

ADDRESS	CITY	STATE	ZIP

PRIMARY BILLING PARTY	ORDERING MD
INSURANCE CARRIER	Physician's Name LAST
POLICY #	FIRST
GROUP#/ENROLLMENT CODE	❑ FAX TO
INSURANCE ADDRESS	❑ CALL TO

SUBSCRIBER RELATIONSHIP TO PATIENT

CLINICAL PATIENT HISTORY

GYNECOLOGY (PAP-HPV TESTING)

HISTORY:

- ❑ LMP ________
- ❑ Prev. Dys/Malignancy ________
- ❑ Concurrent Biopsy
- ❑ Pregnant
- ❑ Postpartum
- ❑ Hysterectomy
- ❑ Post menopausal
- ❑ Post meno. bleeding
- ❑ IUD
- ❑ BCP/Hormones

TEST TYPE:

❑ Routine ❑ Diagnostic

SOURCE:

- ❑ Cervical/Endocervical
- ❑ Vaginal

TEST CODE	TEST DESCRIPTION
❑ TPAPI	Thin Prep PAP with Image
❑ TPRHI	Thin Prep w/Image, Reflex HPV
❑ TPHPI	Thin Prep PAP, Image and HPV
❑ TPRRI	Thin Prep PAP w/Image, Reflex HPV, Reflex HPV 16/18
❑ TPHRI	Thin Prep PAP w/Image w/HPV reflex to 16/18

MICROBIOLOGY

- ❑ Urine Chlamydia/GC PCR
- ❑ Urine Culture
- ❑ GC/Chlamydia from PAP

MEDICAL CYTOLOGY

TEST:

- ❑ Urine ❑ Voided ❑ Catheterized
  - ❑ Reflex Fish
- ❑ Nipple Discharge
- ❑ Anal PAP
- ❑ Endometrial
- ❑ Body Fluid/Brush/Cyst
  Source: ________
- ❑ FNA (Fine Needle Aspirate)
  Source: ________
- ❑ Other: ________

PRENATAL AFP

- ❑ AFP Tri Screen TRPSC
- ❑ AFP Single Marker AFPMS
- ❑ AFP Quad Screen QUAD2

A. Maternal Weight (lbs) ________

B. EDD: ________
Determined by: ❑ Ultrasound ❑ LMP ❑ Physical Exam

C. Mother's Ethnic Origin: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other ________

D. Number of fetuses: ________

E. Patient is an insulin-dependant diabetic during pregnancy: ❑ Yes ❑ No

F. This is a repeat specimen for the pregnancy (Repeat testing following a positive screen for Down Syndrome or Trisomy 18 is NOT recommended). ❑ Yes ❑ No

G. History of neural tube defect? ❑ Yes ❑ No
If yes, explain: ________

H. Previous pregnancy with Down Syndrome? ❑ Yes ❑ No

I. Pregnancy is from a donor egg? ❑ Yes ❑ No
If yes, age of donor at time of retrieval: ________

J. Cigarette Smoker? ❑ Yes ❑ No

334150110725 DOB: __/__/____ Pt. Full Name: Collect: __/__ __:__ BY:	334150110725 DOB: __/__/____ Pt. Full Name: Collect: __/__ __:__ BY:	334150110725 DOB: __/__/____ Pt. Full Name: Collect: __/__ __:__ BY:
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FOR OFFICIAL USE ONLY

__/__/__

- __ S-SST
- __ R-RED
- __ U-UR.Cup
- __ Sputum
- __ Vial
- __ Slide

Notice to Physicians:
Diagnosis codes must be provided for each test ordered. Only tests you believe are appropriate for patient care should be ordered. Medicare will only pay for tests that are medically necessary for the diagnosis and treatment of the patient. Medicare does not generally cover routine screening tests.

Form# IRL-B; rev. 10/2018

SOURCE 4 • TO REORDER CALL (804) 794-5923

Laboratories
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PRIMARY BILLING PARTY

INSURANCE CARRIER
POLICY #
GROUP#/ENROLLMENT CODE
INSURANCE ADDRESS
SUBSCRIBER RELATIONSHIP TO PATIENT

ORDERING MD

Physician's Name LAST FIRST
❑ **FAX TO**
❑ **CALL TO**

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FOR OFFICIAL USE ONLY	__ S-SST	__ Sputum
	__ R-RED	__ Vial
___/___/___	__ U-UR.Cup	__ Slide

DOB:___/___/______ Pt. Full Name: ______ Collect: ___/___ ___:___ BY: ______
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