Pathcare DIAGNOSTICS INC.

REQUISITION FORM

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Temecula, CA 92590

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Yorba Linda, CA 92886

PATIENT INFORMATION		REQUESTING PHYSICIAN INFORMATION	
LAST NAME	FIRST NAME	LAST NAME	FIRST NAME
GENDER ○M ○F ○Other	DATE OF BIRTH	UPIN NUMBER	NPI NUMBER
HOME ADDRESS		CLINIC ADDRESS	
HOME PHONE	WORK PHONE	OFFICE PHONE	OFFICE FAX
INSURANCE INFORMATION		DATE OF PROCEDURE	

CLINICAL INFORMATION	PHYSICIAN ACKNOWLEDGEMENT AND CERTIFICATION
HISTORY	The undersigned physician acknowledges that: 1) The test ordered is medically necessary; 2) If test is ordered for the purposes of screening, the likelihood of denial of payments has been explained to the patient who has signed Advanced Beneficiary Notice and agreed to be personally and financially responsible for payment of denied test.
DIAGNOSIS	ORDERING MD SIGNATURE

CYTOLOGY SPECIMENS
(PLEASE CHECK ALL APPROPRIATE BOXES)

GYN SPECIMENS (PAP TEST)

PURPOSE OF THE TEST
- ☐ SCREENING (ONCE/2YEAR)
- ☐ DIAGNOSTIC (AS PER SIGNS & SYMPTOMS)

METHOD OF COLLECTION
- ☐ CONVENTIONAL
- ☐ LIQUID-BASED

SOURCE OF SPECIMEN
- ☐ CERVICAL
- ☐ VAGINAL

DATE OF LAST PAP TEST_____

RESULT OF LAST PAP TEST
- ☐ NORMAL
- ☐ ASC-US
- ☐ AGUS
- ☐ LSIL
- ☐ HSIL
- ☐ UNKNOWN

MENSTRUAL HISTORY
- ☐ LMP
- ☐ POSTMENOPAUSAL

OBSTETRIC HISTORY
- ☐ PREGNANT (WEEKS)
- ☐ POST-PARTUM (WEEKS)

OTHERS
- ☐ B.C.P.
- ☐ I.U.D.
- ☐ HORMONE
- ☐ CHEMOTHERAPY
- ☐ RADIATION

NON GYN SPECIMENS

URINARY
- ☐ VOIDED URINE
- ☐ CATHETERIZED URINE
- ☐ BLADDER WASH
- ☐ URETHRAL WASHING

PULMONARY
- ☐ SPUTUM
- ☐ BRONCHIAL WASH
- ☐ BRONCHIAL BRUSH
- ☐ BROCHOALVEOLAR LAVAGE

BODY CAVITY FLUID
- ☐ SPINAL FLUID
- ☐ PLEURAL FLUID
- ☐ PERICARDIAL FLUID
- ☐ ASCITIC FLUID
- ☐ ABDOMINAL WASH
- ☐ PELVIC WASH

FINE NEEDLE ASPIRATION (FNA)
- ☐ SPECIFY SITE _____

HISTOLOGY SPECIMENS

ANATOMIC SITE	NAME OF PROCEDURE	PREVIOUS ABNORMAL HISTOLOGY