Stanford HEALTH CARE
STANFORD MEDICINE
www.stanfordlab.com

CYTOPATHOLOGY

300 Pasteur Drive, Room H2110 • Stanford, CA 94305-5624 •
Phone: (650) 736-9861 • Fax: (650) 725-7409
Brittany J. Holmes, MD, Cytopathology Director

Patient Information

Patient Name (Last) (First) | Date Of Birth

Referring Facility MRN | Sex M F | Patient's Phone Number ( )

Patient Address | City | State | Zip Code

Collection Date (REQUIRED) | **Time in Formalin (REQUIRED for breast FNA)**

Requestor Information

Practice Name & Address

Physician Email:

Phone No. | Fax No.

BILL TO:

ABN is Located on Last Page

❑ Patient ❑ PPO ❑ HMO* ❑ Client ❑ Medicare ❑ Outpatient ❑ Inpatient

HMO Insurance Authorization # _____

**Referring facility is responsible for obtaining HMO authorization. If claim is denied due for lack of authorization, the referring facility will be billed for services*

Insurance Info: Attach a copy of front & back of Insurance card or face sheet.
Technical (lab) and professional (M.D.) charges are billed separately.

For Lab Use Only

REQUIRED INFORMATION **ICD Code(s) -**

Requesting Physician

Physician Name | Date | Physician NPI # | **Physician Signature - REQUIRED**

COPIES TO: (Name & Address, Fax & Phone)

SPECIMEN LABELS

GYN CYTOLOGY SPECIMENS: PAP TEST

Last Menses (LMP Date): | Previous Abnormal Pap - Date/specify:

☐ Postmenopausal ☐ Pregnant ☐ Postpartum | Chemotherapy? ☐ No ☐ Yes, When:

Radiation? ☐ No ☐ Yes, When: | Current Hormone Therapy? ☐ No ☐ Yes, Specify:

Check For All Medicare Patients ☐ Low Risk Screening ☐ High Risk Screening ☐ Diagnostic Pap Smear

Specimen Source ***(Required):*** ☐ Cervical/Vaginal ☐ Vaginal ☐ Anal

TESTS REQUESTED

Age Based Pap/HPV Testing

☐ Under 30 *(Cytology only – no HPV orders)*
☐ 30-65 *(HPV co-testing with reflex to genotyping if Pap Negative /HPV Positive)*

Non-Age Based Pap/HPV Testing

☐ Pap Only
☐ HPV only
☐ Pap & HPV Co-Test
☐ Pap and HPV Co-Testing w/ reflex to genotyping if Pap neg/HPV Pos
☐ Pap w/ reflex to HPV if ASC-US
☐ Pap w/ reflex to HPV if ASC-US & above
☐ HPV only w/ reflex to genotyping if positive
☐ Other: Conventional Pap

VIROLOGY TESTING

☐ GC/Chlamydia ☐ Chlamydia Trachomatis ☐ Neisseria Gonorrhoeae (GC) ☐ Trichomoniasis

Specimen Source ***(Required):*** ***(if not ThinPrep Vial)*** ☐ Vagina *(Swab)* ☐ Urethra *(Swab)* ☐ Cervix *(Swab)* ☐ Urine

NON-GYN CYTOLOGY SPECIMENS

LUNG

☐ Sputum
☐ Bronchial Brush, Site: _____
☐ Bronchial Wash, Site: _____
☐ Bronchoalveolar Lavage (BAL)
☐ (GMS) Grocott Methenamine Silver Stain for Fungus and PCP
☐ Other Stains: _____

BODY CAVITIES

☐ Pleural Fluid _____
☐ Pericardial Fluid
☐ Abdominal Fluid
☐ Pelvic Wash

URINE SPECIMENS

Source: ☐ Voided ☐ Catheterized ☐ Bladder Wash
☐ Cytology Only
☐ Cytology with Reflex to Bladder Cancer Testing by UroVysion FISH™
☐ Bladder Cancer Testing by UroVysion FISH™

CENTRAL NERVOUS SYSTEM

☐ (CSF) Cerebrospinal Fluid
☐ Shunt

MISCELLANEOUS SITE

☐ Other: _____

FINE NEEDLE ASPIRATION (FNA) SPECIMENS

Site A: _____ ☐ Left ☐ Right
Air Dried Smears (qty): _____
Fixed Smears (qty): _____
Other material (specify): _____

Site B: _____ ☐ Left ☐ Right
Air Dried Smears (qty): _____
Fixed Smears (qty): _____
Other material (specify): _____

Site C: _____ ☐ Left ☐ Right
Air Dried Smears (qty): _____
Fixed Smears (qty): _____
Other material (specify): _____

CLINICAL HISTORY: _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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