Center for Molecular Cancer Diagnostics, INC.

Cytology, ThinPrep PAP

Alias: PAP; ThinPrep PAP;

Methodology Name And Description:	Microscopy
Specimen Requirements:	Testing Volume/Size: One vial; Type: Fluid PAP; Container: Thin Prep;
Special Info:	Label Thin Prep sample vial with patient's name and unique identifier. Collect the sample by scraping the ectocervix circumferentially with a plastic scraper and rotating a cytobrush in the endocervical os. Rinse both devices thoroughly in the Thin Prep vial. Cap vial tightly and send to laboratory. HPV DNA and GC/ Chlamydia tests, molecular detection methodologies, can be performed on the ThinPrep pap test sample submitted in CYTYC ThinPrep PreserveCYT solution. REQUIRED BY FEDERAL LAW: Specimen must be accompanied by Cytology requisition or electronic equivalent, giving patient's name, age, clinic number, last menstrual period, attending physician, clinical diagnosis including patient's pertinent medications, time, date and source of specimen submitted. Indicate if it is a screening pap, high risk screening pap or diagnostic pap smear (I.C.D - 9 code required). Also, refer to HPV DNA Assay or GC/Chlamydia Amplification.
Clinical Info:	Evaluation for atypical cells suspicious or diagnostic of malignancy
Days Performed:	Monday – Friday (CMCD Holidays Excluded)
Reported:	1 -2 Days from receipt of acceptable specimen in lab
Reference Range	Cytology, ThinPrep PAP - Normal
CPT Code(s):	88141 (or 88141 if reviewed by cytotech only)

CLIA# 36D2061372
CAP# 7541618

ADDRESS: 8285 Darrow Road, Ste 101 Twinsburg, OH 44087
PHONE: 330-405-2623

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LAB USE ONLY

Received by:

Date Rec'd: | Time Rec'd:

ACCOUNT INFORMATION

Account No. | **Phone No.**

Treating Physician | **UPIN No.**

Requesting Physician Signature

I certify that I intend to order the services indicated which I consider medically necessary for the diagnosis and treatment of the patient. In accordance with CMS guidelines, all laboratory orders must either be signed by the ordering physician on the requisition or be documented and signed in the patient's medical record.

Duplicate Report To:

Address:

Fax:

PATIENT INFORMATION

Last Name | **MI**

First Name

Street | **City**

State | **Zip** | **Phone**

Sex: ☐ (M) ☐ (F) | **DOB**

Patient ID No. | **Chart No.**

BILLING INFORMATION

Bill to: Select One

☐ **Medicare** ☐ **Medicaid** ☐ **Patient's Insurance** ☐ **Physician Bill** ☐ **Self Pay** ☐ **Other Insurance**

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD

Patient is: ☐ **Subscriber** ☐ **Spouse** ☐ **Other Dependent**

Primary Insurance Name: | **Policy No.:**

Group No. | **Insured's Name:**

Address: | **City:** | **State:** | **Zip:**

Secondary Insurance Name: | **Policy No.:**

Group No. | **Insured's Name:**

Address: | **City:** | **State:** | **Zip:**

PAP/GYNECOLOGY

ICD-9 Code | Volume | ML/CC

Collection: Date | Collection Method: ☐ ThinPrep Only

Test Requested: ☐ PAP ☐ HR HPV ☐ Gonorrhea/Chlamydia ☐ Gonorrhea Only ☐ Chlamydia Only

GYN Source ☐ Cervix ☐ Endocervix ☐ Vaginal

Clinical History LMP/Menopause Date | Last Pap Test Date | History of Abnormal PAP: ☐ Y ☐ N

Results

Additional Information ☐ High Risk Patient ☐ AUB ☐ BCP (Birth Control Pills) ☐ Carcinoma ☐ Chemotherapy/Radiation DX
☐ Hormone Rx ☐ Hysterectomy - Total ☐ Hysterectomy - Subtotal (Cervix Present) ☐ Post Menopause ☐ Post Partum ☐ Pregnancy

PATIENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

Patient Signature _____ **Date** _____