Non–Gynecologic Cytology
Request Instructions

If you have any questions, please contact your Allina Health Laboratory Account Representative for assistance.

Numbers of topics indicate the position on the Non-Gynecologic Cytology Request form diagramed on the reverse side.

1. Your site demographic information will be preprinted in this area.
   a. Indicate the **Ordering Provider.**

2. If not preprinted, indicate your billing preference.

3. The date and time of collection must be furnished.

4. Complete the patient information/demographics including name, gender, date of birth and address. Insurance policy information is essential if the work is to be billed to the patient's insurance.

5. If copies of the report are to be sent to locations/providers other than the ordering provider, include full names of those providers here.

6. Indicate the diagnosis/reason for the procedure.

7. Provider signatures are not required, providing there is record of the order noted in the patient's medical record.

8. Indicate pertinent clinical history, i.e. Hx of cancer, chemo/radiation therapy, etc.

9. Indicate the testing requested under the appropriate source:

A. Urine:
Cytology only
Cytology *and* FISH
Cytology with reflex to FISH

B. Anal ThinPrep®:
Cytology only
Cytology *and* HPV
HPV only

C. Other Source:
Specify Source

LAB08

ALLINA HEALTH LABORATORY
NONGYNECOLOGIC CYTOLOGY REQUEST
2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
Phone: 612-863-4678 • Fax: 612-863-4067
www.allinahealth.org/laboratory

BILL TO: MUST CHECK ONE ☐ **CLIENT** ☐ **PATIENT/INSURANCE** **2**

☐ MEDICARE SECONDARY PAYER (MSP) INFORMATION REQUIRED. (INTERNAL USE ONLY) ...s been verified with beneficiary or representative ... of service and documentation is on file. ☐ MSP Collected

1

DATE & TIME COLLECTED **3**

SOCIAL SECURITY # - -

☐ MALE ☐ FEMALE

BIRTH DATE / /

PATIENT NAME (LAST) (FIRST) (M.I.)

CHART #

PATIENT ADDRESS (STREET) CITY

STATE ZIP **4**

PATIENT PHONE ( )

INSURANCE

☐ **MEDICARE PRIMARY** ☐ **MEDICARE SECONDARY**

MEDICARE

MEDICAL ASSISTANCE NUMBER STATE

INSURANCE CO. NAME

RELATIONSHIP OF PATIENT TO INSURED ☐ SELF ☐ SPOUSE ☐ DEPEND. ☐ OTHER

POLICY HOLDER'S NAME

POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT) / /

SUBSCRIBER ID #

GROUP #

Copies of Pathology Reports should be sent to:

Physician: _____
First Name MI Last Name

Referring: _____ **5**

Other: _____

Other: _____

Dx1 **Dx2** **6** **Dx3** **Dx4**

PHYSICIAN SIGNATURE **7**

CLINICAL HISTORY/DIAGNOSIS

8

URINE (LAB6301A, LAB12482): **9A**

☐ Cytology only
☐ Cytology *and* FISH
☐ Cytology with Reflex FISH if Cytology is Abnormal
**FISH Only (No Cytology) - *Use Cytogenetics request*

ANAL THINPREP: **9B**

☐ Cytology Only **(LAB6301B, LA...**
☐ Cytology *and* HPV **(LAB6301B...**
☐ HPV Only* **(LAB994)**
Risk: ☐ Low ☐ High ☐ Both
* *Must be collected in Digene vial*

OTHER SOURCE (LAB6301): **9C**

Specify: _____

FOR LAB USE ONLY

Description:

SLIDES: SMR TP Cytospin

Air dried _____ _____ _____

Fixed _____ _____ _____

CELL BLOCK:

☐ Yes ☐ No ☐ QNS

SPECIAL STAIN: ☐ Yes ☐ No

☐ Fungus

☐ Mucicarmine

☐ Other _____

Prep Tech Initials/Date_____

CT Diagnosis:

Date_____ Initials_____

Affix
RQ Label
Here

CYTOLNONGYN (11/14)

☐ Ordered by (A#) _____