



# SURGICAL/CYTOPATHOLOGY REQUISITION

Expertise Delivered Personally  
 Michigan Medicine – University of Michigan  
 Department of Pathology – MLabs  
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 Ann Arbor, MI 48109-5054  
 734-936-2598 • 800-862-7284  
 www.mlabs.umich.edu

|        |                        |                 |                         |
|--------|------------------------|-----------------|-------------------------|
| Client | Patient Reg or MRN:    |                 |                         |
|        | Patient Name: Last     | First           | MI                      |
|        | Birthdate:             |                 | Gender: OM OF           |
| Ward   | Ordering Doctor: Last  | First           | NPI#                    |
|        | Ordering Doctor: Phone | Fax             |                         |
|        | Collected By           | Collection Date | Collection Time Oam Opm |

|                     |                                 |                             |                   |                    |
|---------------------|---------------------------------|-----------------------------|-------------------|--------------------|
| Patient Address     | City                            | State                       | ZIP               | Home Phone #       |
| Policy Holders Name | Primary Insurance (Card Name)   | Primary Policy/Contract #   | Primary Group #   | Policy Holders DOB |
| Policy Holders Name | Secondary Insurance (Card Name) | Secondary Policy/Contract # | Secondary Group # | Policy Holders DOB |

|          |   |  |  |   |
|----------|---|--|--|---|
| Bill To: | <input type="checkbox"/> Client/Referring Institution | <input type="checkbox"/> Patient/Insurance | If patient or insurance information is not included or attached to this form, your facility will be billed. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to the referring client. |   |
|          | <input type="checkbox"/> Medicare =                   | <input type="checkbox"/> In Patient on DOS |  | <input type="checkbox"/> Out Patient on DOS |

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

## ICD-10 CODES

## ADDITIONAL INSTRUCTIONS AND/OR TESTS

## RELEVANT HISTORY (SPECIMENS WITHOUT HISTORY NOT ACCEPTED)

Has Patient Received:  Radiation  Cytotoxic Drugs Please Explain:

See MLabs Test Catalog at [www.mlabs.umich.edu](http://www.mlabs.umich.edu) for specimen collection and handling requirements.

### SURGICAL PATHOLOGY CONSULTATION /TEST REQUESTED

Surg Path Evaluation  Renal Biopsy Evaluation  Muscle Biopsy Evaluation  Nerve Biopsy Evaluation

Additional Testing (Specify): \_\_\_\_\_

Specimens requiring STAT sign-out on weekends/holidays require prior approval by a specialty Pathologist. Please call MLabs at 800-862-7284 or 734-936-2598.

Specimen Types (check all that apply):

Wet Tissue  Frozen Tissue  Formalin Fixed  Gluteraldehyde/Karnovsky's  Other: \_\_\_\_\_

Tissue Source/Location (e.g., Lt. Breast): \_\_\_\_\_ Procedure (Nature of Operation): \_\_\_\_\_

Post Op Diagnosis: \_\_\_\_\_

Lab Use Only  
Surg. Accn#: \_\_\_\_\_

### CYTOPATHOLOGY EVALUATION (NON-GYNECOLOGICAL)

Specimen Types (check all that apply):

Fine Needle Aspiration, Specify site: \_\_\_\_\_  Esophageal Brushing  Gastric Brushing

Peritoneal Effusion  Pleural Fluid  Bronchial Washing  Bronchial Brushing

Bronchial Lavage  Sputum  Urine Voided  Urine Catheterized

Bladder Washing  Urine Other (Specify): \_\_\_\_\_

Other Specimen Type (Specify): \_\_\_\_\_

Lab Use Only  
Relevant prior cancer/treatment Hx:

Dx:

### CYTOPATHOLOGY EVALUATION (GYNECOLOGICAL)

Specimen Types (check all that apply):

Cervical/Endocervical  Endocervical Only  Vaginal  Other: \_\_\_\_\_

Screening Pap<sup>1</sup>: This Pap smear is part of the routine physical examination (NO patient complaints).

Diagnostic Pap<sup>1</sup>: Patient has had previous abnormal tests, findings, symptoms, or significant complaints.

Reflexive HPV (High Risk) Test WITH ThinPrep Pap<sup>1</sup>: Specimen will be held 21 days for additional test requests.

If ASCUS Only  If ASCUS or Negative  If Negative  All Atypical/Abnormal Results  For All Results  Do Not Perform

HPV (High Risk) ONLY - NO PAP

Relevant History (Specimens without history not accepted)

LMP: \_\_\_\_\_  Unavailable (For women less than 50 years of age, an LMP or reasonable estimate of days or months must be provided.)

Pregnant: # Weeks \_\_\_\_\_  Post Partum: # Weeks \_\_\_\_\_  Postmenopausal

IUD in place  No  Yes Previous abnormal pap smear  No  Yes Radiation  No  Yes

Abnormal cervix  No  Yes Hormonal Therapy  No  Yes Cancer Hx/Additional relevant Hx:

Previous gynecological surgery  No  Yes Chemotherapy  No  Yes

Lab Use Only  
Dx: