



SURGICAL/CYTOPATHOLOGY REQUISITION

Expertise Delivered Personally

MLabs N-LNC Specimen Processing
Department of Pathology & Clinical Laboratories
2800 Plymouth Rd, Bldg 35
Ann Arbor, MI 48109-2800
734-936-2598 • 800-862-7284
www.mlabs.umich.edu

Client
Ward

Patient Reg or MRN:

Patient Name: Last	First	MI
Birthdate:	Gender: OM	OF
Ordering Doctor: Last	First	NPI#

Collected By	Collection Date	Collection Time	Oam	Opm	Ordering Doctor: Phone	Fax
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: Client/Referring Institution Patient/Insurance

Medicare = In Patient on DOS Out Patient on DOS Non Patient on DOS

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.

ICD-10 CODES

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.

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 for specimen collection and handling requirements.

SURGICAL PATHOLOGY CONSULTATION /TEST REQUESTED <input type="checkbox"/> Surg Path Evaluation <input type="checkbox"/> Renal Biopsy Evaluation <input type="checkbox"/> Muscle Biopsy Evaluation <input type="checkbox"/> Nerve Biopsy Evaluation <input type="checkbox"/> 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): <input type="checkbox"/> Wet Tissue <input type="checkbox"/> Frozen Tissue <input type="checkbox"/> Formalin Fixed <input type="checkbox"/> Gluteraldehyde/Karnovsky's <input type="checkbox"/> 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): <input type="checkbox"/> Fine Needle Aspiration, Specify site: _____ <input type="checkbox"/> Esophageal Brushing <input type="checkbox"/> Gastric Brushing <input type="checkbox"/> Peritoneal Effusion <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Bronchial Washing <input type="checkbox"/> Bronchial Brushing <input type="checkbox"/> Bronchial Lavage <input type="checkbox"/> Sputum <input type="checkbox"/> Urine Voided <input type="checkbox"/> Urine Catheterized <input type="checkbox"/> Bladder Washing <input type="checkbox"/> Urine Other (Specify): _____ <input type="checkbox"/> Other Specimen Type (Specify): _____		Lab Use Only Relevant prior cancer/treatment Hx: Dx:
CYTOPATHOLOGY EVALUATION (GYNECOLOGICAL) Specimen Types (check all that apply): <input type="checkbox"/> Cervical/Endocervical <input type="checkbox"/> Endocervical Only <input type="checkbox"/> Vaginal <input type="checkbox"/> Other: _____ <input type="checkbox"/> Screening Pap ¹ : This Pap smear is part of the routine physical examination (NO patient complaints). <input type="checkbox"/> Diagnostic Pap ¹ : Patient has had previous abnormal tests, findings, symptoms, or significant complaints. Reflexive HPV (High Risk) Test WITH ThinPrep Pap ¹ : Specimen will be held 21 days for additional test requests. <input type="checkbox"/> If ASCUS Only <input type="checkbox"/> If ASCUS or Negative <input type="checkbox"/> If Negative <input type="checkbox"/> All Atypical/Abnormal Results <input type="checkbox"/> For All Results <input type="checkbox"/> Do Not Perform <input type="checkbox"/> HPV (High Risk) ONLY - NO PAP Relevant History (Specimens without history not accepted) LMP: _____ <input type="checkbox"/> Unavailable (For women less than 50 years of age, an LMP or reasonable estimate of days or months must be provided.) <input type="checkbox"/> Pregnant: # Weeks _____ <input type="checkbox"/> Post Partum: # Weeks _____ <input type="checkbox"/> Postmenopausal IUD in place <input type="radio"/> No <input type="radio"/> Yes Previous abnormal pap smear <input type="radio"/> No <input type="radio"/> Yes Radiation <input type="radio"/> No <input type="radio"/> Yes Abnormal cervix <input type="radio"/> No <input type="radio"/> Yes Hormonal Therapy <input type="radio"/> No <input type="radio"/> Yes Cancer Hx/Additional relevant Hx: Previous gynecological surgery <input type="radio"/> No <input type="radio"/> Yes Chemotherapy <input type="radio"/> No <input type="radio"/> Yes		Lab Use Only Dx:

1 By ordering this test, the clinician acknowledges that additional reflex testing and/or pathologist interpretation will be performed and billed at a separate additional charge if indicated.