LABORATORIES

Michigan Medicine Laboratories (MLabs)

N-LNC Specimen Processing 2800 Plymouth Rd, Bldg 35 Ann Arbor, MI 48109-2800

Client	Patient Reg or MRN:			
	Patient Name: Last	First	MI	
Ward	Birthdate:	Gender: OM OF		

SURGICAL/CYTOPATHOLOGY REQUISITION

734.936.2598 • 800.862.7284 • mlabs.umich.edu

FAX: 734.936.0755

FAV. 724 024 07FF						
FAX: 734.936.0755		Ordering Doctor: Last		First	NPI#	
Collected By Collection Date	e Collection Time Oam Opm	Ordering Doctor: Phone		Fax		
Patient Address	City Sta	te ZIP	Home Phone #			
Policy Holders Name	Primary Insurance (Card Name) Primary Polic	y/Contract #	Primary Group #	Policy Holders DOB	
Policy Holders Name	Secondary Insurance (Card Na	me) Secondary Po	blicy/Contract #	Secondary Group #	Policy Holders DOB	
Bill To: ☐ Client/Referring Institution	☐ 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.			
☐ Medicare = ☐ In Patient on DOS	☐ Medicare = ☐ In Patient on DOS ☐ Out Patient on DOS ☐ Non Patient on DO					

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.

Revised: 05-15-2020 X-REFR

ADDITIONAL INSTRUCTIONS AND/OR TESTS

Copy Distribution: White – MLabs Surg Path

RELEVANT HISTORY

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 REQUEST □ Surg Path Evaluation □ Renal Biopsy Evaluatio □ Additional Testing (Specify): Specimens requiring STAT sign-out on weekends/holidays red	on			erve Biopsy Evalua	_	
Specimen Types (check all that apply):	, ,					
☐ Wet Tissue ☐ Frozen Tissue ☐ Formalin Fixe	d □ Gluteraldehvde/K	arnovsky's	□ Ot	ther:		
Tissue Source/Location (e.g., Lt. Breast):					_	
Post Op Diagnosis:					_ Lab Use Only	
					Surg. Accn#:	
CYTOPATHOLOGY EVALUATION (NON-GYNECOLOGICA	AL)				Lab Use Only	
Specimen Types (check all that apply):	•				Relevant prior cancer/treatment Hx:	
☐ Fine Needle Aspiration, Specify site:	□ Esophageal Brush	ina	□Ga	astric Brushing	noistant prior dancer, a datinent risk	
☐ Peritoneal Effusion ☐ Pleural Fluid	☐ Bronchial Washing	-		onchial Brushing		
☐ Bronchial Lavage ☐ Sputum	☐ Urine Voided		□Ur	ine Catheterized	Dx:	
$\ \square$ Bronchial Lavage $\ \square$ Sputum $\ \square$ Bladder Washing $\ \square$ Urine Other (Specify):					_	
CYTOPATHOLOGY EVALUATION (GYNECOLOGICAL)						
Specimen Types (check all that apply):				Lab Use Only Dx:		
11.5	□ Vaginal □ Other: _				DX.	
☐ Screening Pap¹: This Pap smear is part of the routine p☐ Diagnostic Pap¹: Patient has had previous abnormal te Reflexive HPV (High Risk) Test WITH ThinPrep Pap¹: Spe						
☐ If ASCUS Only ☐ If ASCUS or Negative ☐ If Nega☐ HPV (High Risk) ONLY - NO PAP					Perform	
Relevant History (Specimens without history not accepted	d)					
LMP: Unavailable (For women	en less than 50 years of age, ar	LMP or reas	sonable	e estimate of days	or months must be provided.)	
□ Pregnant: # Weeks □ Post Partum: # Weeks	🗆 Postmenopausal					
IUD in place ○ No ○ Yes Previ	ous abnormal pap smear	\bigcirc No \bigcirc Y	'es	Radiation	○ No ○ Yes	
Abnormal cervix O No O Yes Horm	nonal Therapy	\bigcirc No \bigcirc Y	'es	Cancer Hx/Additi	onal relevant Hx:	
Previous gynecological surgery ○ No ○ Yes Chem	notherapy	\bigcirc No \bigcirc Y	'es			

Yellow – MLabs SP

Pink - Client