NOTE: Yellow Highlighted Fields Required

Name: (Last)

Name: (First) MI: Phone

Address:

City: State Zip

Soc. Sec. No.: Birthdate Sex: ☐ F ☐ M

Please Bill To: ☐ Acct ☐ Patient / Insurance

Subscriber's Name

Medicare # ☐ Black Lung
Retirement date: ☐ Work Related / Accident

Medicaid #

Other/Secondary Insurance

ID #s

Address

Collection Time: AM/PM

DATE

Volume mL

Duration Hrs

COMMENTS:

UP HEALTH SYSTEM LABORATORY

TISSUE/CYTOLOGY Laboratory Request Form

850 West Baraga Avenue • Marquette,Michigan 49855
(906) 449-3220 • 1-888-818-3879 • CLIA#23D0038098

Account Information

PATIENT SPECIFIC ICD-10-CM DIAGNOSIS CODES ARE REQUIRED FOR INSURANCE BILLING. ONLY A PARTIAL LIST IS PROVIDED BELOW.

Diagnosis codes must be medically appropriate for the patient's condition and consistent with documentation in the patient's medical record. UPHSM cannot recommend specific diagnosis codes.

	ICD-10 CODE	DIAGNOSIS
	Z01.419	Encounter for gyn exam (general) (routine) without abnormal findings
	Z01.411	Encounter for gyn exam (general) (routine) w abnormal findings
	Z12.4	Encounter for screening for malignant neoplasm of cervix
	Z12.72	Encounter for screening for malignant neoplasm of vagina
	Z32.00	Encounter for pregnancy test, result unknown
	Z33.1	Pregnant state, incidental
	Z39.2	Encounter for routine postpartum follow-up
	Z11.51	Encounter for screening for human papillomavirus (HPV)

	ICD-10 CODE	DIAGNOSIS
	R87.619	Unsp abnormal cytolog findings in specimen from cervix uteri
	R87.610	Atyp squam cell of undetermined significant cyto smr cervix (ASC-US)
	R87.611	Atyp squam cell not excl hi grade intrepith lesion cyto smear cervix
	R87.612	Low grade intrepith lesion cyto smear cervix (LGSIL)
	R87.613	High grade intrepith lesion cyto smear cervix (HGSIL)
	R87.810	Cervical high risk HPV DNA test positive
	R87.615	Unsatisfactory cytologic smear of cervix

GYN CYTOLOGY WITH OPTIONAL ANCILLARY TEST REQUESTS

TEST REQUESTED

☐ Conventional Pap
☐ Maturation Index (Hormone Evaluation)
☐ Thin Prep Pap® Test*
☐ Thin Prep * w/reflex **High Risk** HPV typing **(if ASC-US Dx only)**
☐ Thin Prep * w/reflex **High Risk** HPV typing **(if ASC-US diagnosis or greater)**
☐ HPV DNA assay-(independent of pap result) please specify:
  ☐ High Risk HPV (Diagnostic)
  ☐ High Risk HPV (Screening) (Z11.51)

LMP _____ /_____ /_____

Source: ☐ Cervical ☐ Endocervical ☐ Vaginal

CLINICAL HISTORY

☐ Pregnant ☐ Post Partum
☐ Post Menopausal ☐ Hormone Therapy
☐ Hysterectomy ☐ Previous dysplasia
☐ Surgery ☐ Pelvic Radiation
☐ Previous Ca; site: _____

Referring Facility Case #: _____

PREVIOUS PAP TEST: Date: _____ / _____ / _____

Diagnosis: _____

NON-GYN CYTOLOGY

☐ Body fluid, source _____ ☐ FNA, source_____
☐ Breast FNA
  ☐ Left ☐ Right ☐ Cyst ☐ Solid
☐ Nipple discharge
☐ Urine, source ☐ Catheter speciman ☐ Voided ☐ Cystoscopic/bladder washing
  ☐ Urine Cytology Only ☐ Urine Cytology **AND** Urovysion® Fish
  ☐ Urine Cytology with **reflex** to FISH if cytology is atypical ☐ urovysion® Fish only

Thyroid
☐ Left ☐ Right ☐ Cyst ☐ Solid

☐ Sputum
☐ Brushing, source _____
☐ Washing, source _____

Diagnosis _____

TISSUE PATHOLOGY TESTS

Pre-op Diagnosis _____ **Post-op Diagnosis** _____

Surgical Procedure _____

History: _____

Source (required – list parts separately)

A. _____
B. _____
C. _____
D. _____

Clinical Impression: _____

Nurse Practitioner / PA Signature | Physician / Supervising Physician Signature | Date | Time | Additional Copies To

WHITE COPY: UPHSM COPY YELLOW COPY: CLIENT COPY