# CYTOPATHOLOGY

300 Pasteur Drive, Room H2110 • Stanford, CA 94305-5624 • Phone: (650) 736-9861 • Fax: (650) 725-7409

Brittany J. Holmes, MD, Cytopathology Director

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**Patient Information**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>(Last)</th>
<th>(First)</th>
<th>Date Of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Referring Facility MRN</th>
<th>Sex</th>
<th>Patient’s Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collection Date</th>
<th>Time in Formalin</th>
</tr>
</thead>
<tbody>
<tr>
<td>(REQUIRED)</td>
<td>(REQUIRED for breast FNA)</td>
</tr>
</tbody>
</table>

**Referrer Information**

**Practice Name & Address**

**Physician Email:**

Phone No.  | Fax No.  |
-----------|----------|

**Requestor Information**

**Physician Name**

Physician Email: ______________________

Physician NPI #: ______________________

Physician Signature - REQUIRED

**COPIES:**

(Name & Address, Fax & Phone)

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**GYN CYTOLOGY SPECIMENS: PAP TEST**

- **Last Menses (LMP Date):**
- **Previous Abnormal Pap - Date/specify:**

- **Postmenopausal**
- **Pregnant**
- **Postpartum**
- **Chemotherapy?**
- **No**
- **Yes, When:**

- **Radiation?**
- **No**
- **Yes, When:**

**Check For All Medicare Patients**

- **Low Risk Screening**
- **High Risk Screening**
- **Diagnostic Pap Smear**

**Specimen Source (Required):**

- **Cervical/Vaginal**
- **Vaginal**
- **Anal**

**TESTS REQUESTED**

**Age Based Pap/HPV Testing**

- Under 30 (Cytology only – no HPV orders)
- 30-65 (HPV co-testing with reflex to genotyping if Pap Negative/HPV Positive)

<table>
<thead>
<tr>
<th>Pap Only</th>
<th>HPV only</th>
<th>Pap &amp; HPV Co-Test</th>
<th>Pap w/ reflex to HPV if ASC-US &amp; above</th>
<th>HPV only w/ reflex to genotyping if positive</th>
<th>Pap w/ reflex to HPV if ASC-US &amp; above</th>
</tr>
</thead>
</table>

**Non-Age Based Pap/HPV Testing**

- Pap Only
- HPV only
- Pap & HPV Co-Test
- Pap w/ reflex to HPV if ASC-US & above
- HPV only w/ reflex to genotyping if positive
- Pap w/ reflex to HPV if ASC-US & above

**VIROLOGY TESTING**

- **GC/Chlamydia**
- **Chlamydia Trachomatis**
- **Neisseria Gonorrhoeae (GC)**
- **Trichomoniasis**

**Source (Required):**

- **Vagina (Swab)**
- **Cervix (Swab)**
- **Urethra (Swab)**
- **Urine**

**OTHER SMEDAIN SPECIMENS**

**LUNG**

- **Sputum**
- **Bronchial Brush, Site:**
- **Bronchial Wash, Site:**
- **Bronchoalveolar Lavage (BAL)**

**BODY CAVITIES**

- **Pleural Fluid**
- **Pericardial Fluid**
- **Abdominal Fluid**
- **Pelvic Wash**

**UREINE SPECIMENS**

- **Source:**
- **Voided**
- **Catheterized**
- **Bladder Wash**
- **Cytology Only**
- **Cytology with Reflex to Bladder**
- **Cancer Testing by UroVysion FISH™**
- **Bladder Cancer Testing by UroVysion FISH™**

**CENTRAL NERVOUS SYSTEM**

- **(CSF) Cerebrospinal Fluid**
- **Shunt**

**MISCELLANEOUS SITE**

- **Other:**

**FINE NEEDLE ASPIRATION (FNA) SPECIMENS**

<table>
<thead>
<tr>
<th>Specimen Source</th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site B:</td>
<td></td>
<td></td>
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<tr>
<td>Site C:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Air Dried Smears (qty):</th>
<th>Fixed Smears (qty):</th>
<th>Other material (specify):</th>
</tr>
</thead>
</table>

**CLINICAL HISTORY:**

Revised 8/20
Advance Beneficiary Notice of Non-coverage
(ABN)

NOTE: If Medicare doesn’t pay for D. __________ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. __________ below.

D. 

E. Reason Medicare May Not Pay: 

F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. __________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

□ OPTION 1. I want the D. __________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

□ OPTION 2. I want the D. __________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

□ OPTION 3. I don’t want the D. __________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: 

J. Date:

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