

CellNetix Pathology & Laboratories



1124 Columbia Street, Suite 200
Seattle, WA 98104
Toll Free (866) 236-8296
Billing (844) 503-8965
WWW.CELNETIX.COM

07-22-2015



RQ254612 PI Name: _____



RQ254612 PI Name: _____



RQ254612 PI Name: _____



RQ254612 PI Name: _____



RQ254612 PI Name: _____



RQ254612 PI Name: _____

Patient Information				Specimen Information	
PATIENT LAST NAME	FIRST	M.I.	SEX	COLLECTION DATE	TIME
PATIENT D.O.B.	PATIENT SOCIAL SECURITY NUMBER	PHONE		ICD-10 CODE(S)	

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

Billing Information

INSURANCE COMPANY NAME AND ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURANCE/SUBSCRIBER ID# _____ SUBSCRIBER NAME/RESPONSIBLE PARTY _____

INSURANCE/GROUP# _____ MEDICARE# _____ PRIMARY SECONDARY

SECONDARY _____ MEDICAID (coupon attached) _____

NO INSURANCE WORKER'S COMP YES NO

Referring MDs

CC report to: First and Last Names

INTERNAL USE ONLY

GYN CYTOLOGY		HISTOLOGY (TISSUE SPECIMENS)	
<p>Step #1</p> <p><input type="checkbox"/> Pap only</p> <p><input type="checkbox"/> Pap if ASCUS reflex to HPV High Risk (21 to 29yrs*)</p> <p><input type="checkbox"/> Pap if ASCUS reflex to HPV High Risk, if Positive reflex to HPV Geno (16/18)</p> <p><input type="checkbox"/> Pap with HPV High Risk - COTEST (30 yrs and Over*)</p> <p><input type="checkbox"/> Pap with HPV High Risk, if POSITIVE reflex to HPV Geno (16/18)</p> <p>Step #2 (From Pap Vial)</p> <p><input type="checkbox"/> Chlamydia and Gonorrhea</p> <p><input type="checkbox"/> Chlamydia <input type="checkbox"/> HSV 1&2 by PCR</p> <p><input type="checkbox"/> N. Gonorrhea <input type="checkbox"/> Trichomonas (ThinPrep™)</p>	<p>HPV Testing Only No Pap Requested</p> <p><input type="checkbox"/> HPV High Risk</p> <p><input type="checkbox"/> HPV High Risk and Reflex to Genotype if Pos.</p> <p><input type="checkbox"/> HPV HR Genotyping</p>	<p>SPECIMEN SITE</p> <p>A _____</p> <p>B _____</p> <p>C _____</p> <p>D _____</p> <p>Procedure/Clinical History/Other Information: _____</p> <p>For breast specimens, time in formalin: _____</p>	<p>MOLECULAR</p> <p><input type="checkbox"/> CellSwab™ - Vaginitis Panel, Expanded TMA (Aptima, Swab - White Label)</p> <p><input type="checkbox"/> CellSwab™ - Vaginitis Panel, Expanded TMA + GC/CT (Aptima, Swab - White Label)</p> <p><input type="checkbox"/> Chlamydia/Gonorrhea (Aptima, Swab - White Label)</p> <p><input type="checkbox"/> Chlamydia (Aptima, Swab - White Label)</p> <p><input type="checkbox"/> Gonorrhea (Aptima, Swab - White Label)</p> <p><input type="checkbox"/> Anal/Rectal - Chlamydia / Gonorrhea (Aptima, Swab - Orange Label)</p> <p><input type="checkbox"/> BD Affirm VPIII™ - Vaginitis Panel (BD Affirm, Swab)</p> <p><input type="checkbox"/> Urovysion™ - Bladder Cancer FISH (Urine)</p> <p>Source: <input type="checkbox"/> Endocervical <input type="checkbox"/> Vaginal <input type="checkbox"/> Urethral</p>
<p>LMP: Month: _____ Day: _____ Year: _____</p> <p><input type="checkbox"/> ENDO/ECTO <input type="checkbox"/> ENDOCX <input type="checkbox"/> ECTOCERVIX <input type="checkbox"/> CERVIX <input type="checkbox"/> VAGINA</p> <p><input type="checkbox"/> Check if tissue specimen is submitted simultaneously with Pap</p> <p>CLINICAL HISTORY (check all that apply):</p> <p><input type="checkbox"/> Pregnant <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Previous CIN/HPV <input type="checkbox"/> Cervical Stump <input type="checkbox"/> History of Malignancy</p> <p><input type="checkbox"/> Postpartum <input type="checkbox"/> IUD <input type="checkbox"/> Previous GYN Cone/LEEP <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Chemotherapy</p> <p><input type="checkbox"/> Postmenopausal <input type="checkbox"/> DES Exposure <input type="checkbox"/> Laser Therapy <input type="checkbox"/> Radiation</p> <p><input type="checkbox"/> Hormones <input type="checkbox"/> Other</p>		<p>NON-GYN CYTOLOGY</p> <p><input type="checkbox"/> FINE NEEDLE ASPIRATION, Source: _____</p> <p><input type="checkbox"/> FLUID, Source/Laterality: _____</p> <p><input type="checkbox"/> RESPIRATORY CYTOLOGY: <input type="checkbox"/> BAL <input type="checkbox"/> Brushing <input type="checkbox"/> Washing <input type="checkbox"/> Sputum</p> <p>Source/Laterality: _____</p> <p><input type="checkbox"/> URINE CYTOLOGY <input type="checkbox"/> REFLEX TO UROVYSION IF ATYPICAL <input type="checkbox"/> PCA3</p> <p><input type="checkbox"/> Voided <input type="checkbox"/> Catheterized <input type="checkbox"/> Bladder Washing <input type="checkbox"/> Barbotage</p> <p><input type="checkbox"/> ANAL-RECTAL CYTOLOGY <input type="checkbox"/> With HPV High Risk <input type="checkbox"/> Reflex HPV if ASCUS</p> <p><input type="checkbox"/> NIPPLE DISCHARGE: <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> HERPES TZANCK SMEAR, Source: _____</p> <p><input type="checkbox"/> OTHER: _____</p>	
<p>PREVIOUS PAP DATE:</p> <p>Month: _____ Day: _____ Year: _____</p> <p>Interpretation:</p> <p><input type="checkbox"/> Unsat. <input type="checkbox"/> Negative <input type="checkbox"/> ASCUS <input type="checkbox"/> ASCH <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL</p> <p><input type="checkbox"/> Other: _____</p>			