MAWD PATHOLOGY GROUP

CYTOPATHOLOGY REQUISITION

APPLY ID STAMP OR STICKER **HERE**

9705 LENEXA DR, LENEXA, KS 66215
PH: (913) 396-8509 / (800) 933-6293 Fax: (913) 495-9759

CLIENT NAME AND ADDRESS	PATIENT NAME (LAST) (FIRST) (MI)		
	SEX	DOB	PATIENT ID

ORDERING PHYSICIAN

COPY REPORT TO:

CC REPORT TO

ADDRESS

CITY STATE ZIP

RESPONSIBLE PARTY & INSURANCE (ATTACH COPIES OF INSURANCE CARDS OR PATIENT DEMOGRAPHIC SHEET)

BILL TO ☐ PATIENT (SELF) ☐ INSURANCE

PT RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURED (IF NOT SELF) | INSURED'S SSN:

ADDRESS CITY STATE ZIP

PHONE NUMBER HOME WORK

☐ See Attached:

Attach All Copies of Insurance

NON-GYNECOLOGICAL CYTOLOGY

Source (check one)

DATE OF COLLECTION: _____

- ☐ CSF
- ☐ Bronchial Wash
- ☐ Bronchial Brush
- ☐ Bronchial Alveolar Lavage
- ☐ Sputum
- ☐ Urine ☐ Voided ☐ Catheterized ☐ Ileal Conduit
- ☐ Abdominal Fluid
- ☐ Pleural Fluid
- ☐ Pericardial Fluid
- ☐ Pelvic Wash
- ☐ Wash (Specify) _____
- ☐ Nipple Discharge (Left/Right)
- ☐ Needle Aspiration ☐ Breast (Left/Right) ☐ Thyroid ☐ Lung ☐ EUS ☐ EBUS ☐ Other (specify)
- ☐ Miscellaneous (specify)
- ☐ Specimen Adequacy Evaluated

CLINICAL DIAGNOSIS and HISTORY (Including Previous Biopsies)

ICD_____
(required)

DIAGNOSIS (LAB USE ONLY)

COMMENTS:

_____CT _____DATE

_____ D.O./M.O.

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient. Further testing may result in additional charges.

WHITE - MAWD Copy CANARY - Physician's Copy