Waterbury Hospital
Waterbury HEALTH

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CLIA# 07D0100126; State Lic. HP-0360

ecpc
EASTERN CONNECTICUT PATHOLOGY CONSULTANTS

Robert A. Schwartz, M.D.
Medical Director of Pathology and Laboratory Medicine

PATHOLOGY/GYN CYTOLOGY REQUISITION

Submitting Physician: _____

Signature: _____

Copy To: _____

MRN #	ACCESION #	DATE OF SERVICE (COLLECTION DATE)	
FINANCIAL #		LOCATION/CLIENT	
MEDICARE NO.	PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NO.	
MEDICAID NO.	ADDRESS (NUMBER AND STREET)	DATE OF BIRTH	SEX ☐ M ☐ F
OTHER	CITY / STATE / ZIP CODE	PHONE NO.	
POLICY NUMBER	SUBSCRIBER'S NAME	RELATIONSHIP TO SUBSCRIBER	
EMPLOYER NAME	EMPLOYER ADDRESS		

COMPLIANCE IS MANDATORY AND REGULATED. For the laboratory to bill properly and receive payment for tests you have ordered, you must include the specific ICD code(s) (or descriptive diagnosis) for each test ordered. It is critical that the diagnosis you provide to the lab is consistent with those recorded in the patients medical record on the date of service. Carriers now require that the same diagnosis be consistent with the ordering physician and performing laboratory.

Medical Release
I authorize the release of any medical information to process a claim and requests payment of any medical insurance benefits to Eastern Connecticut Health Network, inc. / Eastern Connecticut Pathology Consultants, P.C.

_____
SIGNATURE

Medicare Patients - Waiver of Liability (If Applicable)
I have been informed that Medicare will not cover yearly Pap testing in my case. I agree to be personally responsible for payment.

_____
SIGNATURE

CLINICAL INFORMATION/ICD10 DIAGNOSIS CODES: _____

_____

_____

GYN CYTOLOGY

	TESTS REQUESTED	CLINICAL HISTORY
☐ LIQUID BASED PAP ☐ CONVENTIONAL PAP SOURCE: ☐ CERVIX / ENDOCERVIX ☐ VAGINA	☐ ROUTINE SCREENING ☐ REPEAT/DIAGNOSTIC ☐ HPV WITH 16/18 GENOTYPE FOR: ☐ ANY DIAGNOSIS (COTEST) ☐ ASCUS ☐ NEGATIVE OR ASCUS ☐ LSIL ☐ HPV ONLY ☐ GC/CHLYMADIA	LMP (REQUIRED): ☐ INCREASED RISK FOR CERVICAL CANCER ☐ ABNORMAL BLEEDING ☐ PRENATAL ☐ POSTPARTUM ☐ POSTMENOPAUSAL ☐ HORMONE RX ☐ HYSTERECTOMY ☐ COMPLETE/TOTAL ☐ SUPRACERVICAL ☐ OTHER

SURGICAL PATHOLOGY

SPECIMENS:

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

FOR LAB USE ONLY: