



6060 North Central Expressway  
 Suite 262  
 Dallas, TX 75206  
 Phone: 877.232.9924  
 Fax: 469.232.9927  
 www.averodx.com

SCOTT B. SHAPPELL, M.D. PhD., FCAP  
 THOMAS R. MATTISON, M.D., FCAP  
 M. TRAE MATTISON, M.D., FCAP  
 SETH W. COOK, M.D., FCAP  
 TANNER L. MATTISON, M.D., FCAP  
 Diplomates American  
 Board of Pathology

## GYN PATHOLOGY REQUISITION

Specimen Collection Date: \_\_\_\_\_

PATIENT INFORMATION			PHYSICIAN INFORMATION		
Patient Name (Last, First, MI)					
SSN	DOB	Sex M / F			
Address					
City	State	ZIP			
Patient Insurance Information - Please provide copy of insurance card (s)					
DIAGNOSTIC INFORMATION (ICD-9)			CLINICAL INFORMATION (Check all that apply)		
Primary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Ins. <input type="checkbox"/> Patient <input type="checkbox"/> Client Bill Company _____ Policy / ID Number _____ Group Number _____			<input checked="" type="checkbox"/> Check All that Apply.	<b>626.8 Abnormal Bleeding</b>	
Secondary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Ins. <input type="checkbox"/> Patient <input type="checkbox"/> Client Bill Company _____ Policy / ID Number _____ Group Number _____			<input type="checkbox"/> <b>V72.31 Annual Gyn Exam</b>	<b>627.1 Postmenopausal Bleeding</b>	
			<input type="checkbox"/> <b>V22.2 Pregnancy</b>	<b>627.3 Atrophic Vaginitis</b>	
			<input type="checkbox"/> <b>180.9 Malignant Neoplasm Cervix</b>	<b>795.00 Ab. Cervical Pap</b>	
			<input type="checkbox"/> <b>616.0 Cervicitis</b>	<b>795.08 Prev. Unsatisf. Pap.</b>	
			<input type="checkbox"/> <b>616.10 Vaginitis</b>	OTHER _____	
			<input type="checkbox"/> <b>622.10 Dysplasia Cervix</b>		
CYTOLOGY			MOLECULAR		
<b>SPECIMEN SOURCE</b> <input type="checkbox"/> Cervix/Endocervix <input type="checkbox"/> Vagina <input type="checkbox"/> Breast <b>TEST SUBMITTED</b> <input type="checkbox"/> Pap Test - Liquid Based - Thin Prep™ <input type="checkbox"/> Pap Test - Liquid Based - SurePath™ <input type="checkbox"/> DNA Pap (High Risk HPV & Pap)*recommended in women >30Yrs <input type="checkbox"/> HALO™ Breast Pap Test <b>DATE LMP / POSTMENOPAUSAL / HYSTERECTOMY</b> ____ / ____ / ____			<input type="checkbox"/> Prev. Abnl. Pap <input type="checkbox"/> Pregnant <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> ASC-US <input type="checkbox"/> Postpartum <input type="checkbox"/> Depo Provera <input type="checkbox"/> LGSIL <input type="checkbox"/> Postcoital Bleeding <input type="checkbox"/> IUD <input type="checkbox"/> HGSIL <input type="checkbox"/> Abnl. Bleeding <input type="checkbox"/> Oral Contraceptives <input type="checkbox"/> _____ <input type="checkbox"/> Vaginitis <input type="checkbox"/> Prior Conization <input type="checkbox"/> Abnl. Appearing Cx <input type="checkbox"/> Prior Colpo w/Bx <input type="checkbox"/> Other _____		
HISTOLOGY			SPECIMEN LABELS		
<b>TISSUE SPECIMENS</b> 1. _____ C <input type="checkbox"/> E <input type="checkbox"/> V <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> 2. _____ C <input type="checkbox"/> E <input type="checkbox"/> V <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> 3. _____ C <input type="checkbox"/> E <input type="checkbox"/> V <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> 4. _____ C <input type="checkbox"/> E <input type="checkbox"/> V <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> 5. _____ C <input type="checkbox"/> E <input type="checkbox"/> V <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> 6. _____ C <input type="checkbox"/> E <input type="checkbox"/> V <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> <b>Site Key</b> C : Cervix                      E : Endocervix                      V : Vagina S : Skin                         O : Other			The labels found below are for the purpose of identifying the specimens with this requisition. Please affix to the side of each specimen vial you are submitting. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">  _____              123456789   _____              123456789   _____              123456789   _____              123456789   _____              123456789   _____              123456789           </div>		
<b>Additional Information:</b>					

ALL MEDICARE PATIENTS MUST COMPLETE THE FOLLOWING: Medicare will only pay for services determined to be "reasonable and necessary" under section 1662(a) of the Medicare law. If Medicare determines that a particular service is not reasonable and or necessary under Medicare program standards, Medicare will deny payment for that

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_