Regional Medical Diagnostic Lab

1701 St. Julian Place, Suite 100
Columbia, SC 29204
Phone: 803-252-1913 Fax: 803-252-2330

REFERRED BY

PATIENT DEMOGRAPHICS

SOCIAL SECURITY #

PATIENT NAME
LAST ____________ FIRST ____________ M.I. ____

Street ____________

City ____________ State ________ Zip ________

SEX	BIRTH DATE (AGE)	CHART#

HOME PHONE #	WORK PHONE #
( )	( )

PLEASE INCLUDE A COPY OF FRONT AND BACK OF INSURANCE CARD(S).

BILLING INFORMATION

( ) MEDICARE # ____________
( ) MEDICAID # ____________ STATE ________
INSURANCE CO. ____________
INS. CO. ADDRESS ____________
____________ | ________ | ________
POLICY / I.D. # GROUP # EMPLOYER #
EMPLOYER NAME ____________
RELATIONSHIP ( ) SELF ( ) SPOUSE ( ) DEPENDENT
DX #1 ____________ ICD9 CODE ________
DX #2 ____________ ICD9 CODE ________
NAME OF INSURED (if different from patient)
NAME (LAST) ____________ (FIRST) ____________
ADDRESS ____________
CITY ____________ STATE ________ ZIP ______

REQUESTING PHYSICIAN (PLEASE CHECK ONE)

Collection Date ____________ **Time** ________

☐ Call Results to: ( ) ☐ STAT

Send Duplicate Report To: ____________

❑ Pap Smear
❑ Liquid Thin Layer

ANCILLARY TESTING
❑ HPV-High Risk Profile for result of ________
❑ HPV-High and Low Risk Profile for result of ________
❑ ____________
❑ ____________

GYNECOLOGIC (PAP TESTING)

APPROPRIATE BOX MUST BE CHECKED

❑ **DIAGNOSTIC PAP TEST** ICD9 ____________
History of abnormality/signs of medical necessity (Must include ICD 9)

❑ **NON-MEDICARE ROUTINE SCREENING PAP**

❑ **MEDICARE LOW RISK SCREENING PAP** (Medicare pays every 2 yrs)

❑ **MEDICARE HIGH RISK SCREENING PAP** (Meets M'Care standards for more frequent screening than every two years)

CLINICAL INFORMATION / HISTORY

SOURCE ❑ CERVIX ❑ ENDOCERVIX ❑ VAGINA
LMP ____________

❑ PREGNANT
❑ POSTPARTUM
❑ BREASTFEEDING
❑ POSTMENOPAUSAL
❑ HYSTERECTOMY, YR. ______
❑ HORMONE: ________ (Type)
❑ DISCHARGE
❑ VISIBLE LESION OR MASS
❑ NO PAP IN LAST 3 YEARS
❑ ABNORMAL BLEEDING/SPOTTING
❑ IUD
❑ RADIATION
❑ CHEMOTHERAPY
❑ IMMUNOSUPPRESSED
❑ PREVIOUS ABNORMAL PAP
❑ COLPO ABNORMALITY
❑ PREVIOUS ABNORMAL BIOPSY-DATE ______
❑ PRIOR CARCINOMA-SITE ______
❑ DES EXPOSURE

NON-GYNECOLOGIC

CLINICAL INFORMATION (PLEASE INCLUDE):

❑ SPUTUM
❑ BRONCHIAL WASHING R L
❑ BRONCHIAL BRUSHING R L

❑ VOIDED URINE
❑ CATHERIZED URINE
❑ BLADDER WASHING

❑ PLEURAL FLUID
❑ PERICARDIAL FLUID
❑ PERITONEAL FLUID

❑ CUL-DE-SAC
❑ GUTTER R L
❑ DIAPHRAGM R L

❑ CSF

❑ FINE NEEDLE ASPIRATION
❑ THYROID R L
❑ SOLID BREAST MASS R L
❑ LUNG R L
❑ LYMPH NODE R L
❑ LIVER
❑ OTHER: ____________

❑ BREAST NIPPLE DISCHARGE R L
❑ BREAST CYST ASP R L
❑ OVARIAN CYST R L

❑ ESOPHAGEAL
❑ GASTRIC
❑ DUODENAL
❑ COLONIC

❑ OTHER: ____________
(PLEASE SPECIFY)

PRELIM. FNA ASSESS.: ____________
____

OTHER CLINICAL INFORMATION

____
____
____
____