QDxPathology SERVICES

GYN PATHOLOGY REQUISITION

CLIA ID# 31D2026917

PATIENT INFORMATION - ALL REQUIRED

Date of Collection: _____ Time of Collection: _____
Last Name: _____ First Name: _____ MI: _____
Cell #: _____ Email: _____
Home #: _____ Street Address: _____
Apt: _____ City: _____ State: _____ Zip: _____
DOB: (MM/DD/YYYY): _____ / _____ / _____ SSN #: _____
(SSN # required for uninsured patients only)

Gender Identity and Sexual Orientation

- ☐ Male
- ☐ Female
- ☐ Non-Binary/Genderqueer
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Bisexual
- ☐ Other: _____

Race and Ethnicity - Select all that apply

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other: _____

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

REFERRING PHYSICIAN INFO. (Required)

INSURANCE INFO. (Required)

Policyholder Name: _____
Insurance Name: _____
Policy #: _____
Group #: _____

Please provide a copy of the front & back of insurance card(s).

- ☐ Bill Insurance
- ☐ Bill Client
- ☐ Self Pay

SPECIMEN ID: T128353 **LAB ACCESSION #:** _____

SPECIMEN SOURCE

- ☐ Liquid Based (ThinPrep)
- ☐ Conventional Pap Test
- **Site:** ☐ Cervical/Endocervical
- ☐ Fluids/Aspirate
- ☐ Other: _____
- ☐ Vaginal

LMP Date: _____

☐ ICD 10 (required) _____

CYTOPATHOLOGY

- ☐ ThinPrep Pap Test
- ☐ ThinPrep + HPV + CT/NG
- ☐ ThinPrep Pap + HPV
- ☐ ThinPrep Pap + CT/NG
- ☐ ThinPrep Pap reflex to HPV when ASC-US/LSIL
- ☐ Maturation Index
- ☐ HPV Only
- ☐ CT/NG Only

PATIENT HISTORY

- ☐ Pregnant ☐ Postpartum ☐ Post AB ☐ Routine Screen
- ☐ Menopausal _____ years ☐ Post Hysterectomy ☐ TAH ☐ Supercervical

History of Radiation/Other: _____

Discharge: ☐ Vaginitis ☐ Cervicitis ☐ Abnormal Bleeding

Cervix: ☐ Normal ☐ Bleeds on Contact ☐ Erosion ☐ PolyP ☐ Leukolakia ☐ Clinically Suspicious ☐ Other: _____

☐ **Prior Pap Date:** _____ ☐ High Risk Patient

☐ NILM ☐ ASC-US ☐ ASC-H ☐ AGC ☐ AIS ☐ LSIL ☐ HSIL ☐ CA

TISSUE PATHOLOGY

Clinical Diagnosis: _____

Source: ☐ Cervix ☐ Endometrium ☐ Vagina/Vulva ☐ Other: _____

Specimen: ☐ EMC ☐ ECC ☐ LEEP ☐ Cervical Punch Biopsy ☐ Endometrial Biopsy ☐ Vaginal Biopsy ☐ Other

STD PROFILE

- ☐ Urine
- ☐ Vaginal Swab
- ☐ Endocervical/Uretheral Swab
  - ☐ IDC-10 Z11.3 Screening Examination
  - ☐ ICD-10 N46.9 Male Infertility

MICROBIAL VAGINOSIS

- ☐ Vaginitis Panel (BD Swab)
  - ☐ ICD-10N77.1 Vaginitis and Vulvovaginitis

BOTH PATIENT AND PHYSICIAN MUST SIGN to approve testing

By signing below, I confirm I have read the ABN on the reverse side.

Patient Signature: _____

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to QDx Pathology Services and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Physician Signature: _____

CMS requires physician signature on all requisitions. QDx Pathology Services is responsible for verifying signature prior to performing testing.

Ethnicity requires only for Genetic Carrier Screening tests. Many states have enhanced legislation requiring patient consent, genetic counseling or other restrictions for ordering, performing or disclosing the results of a genetic test. Any physician ordering a genetic test must sign here acknowledging that they understand the requirements under the law of the state where the patient resides and has obtained patient consent and/or taken such other steps as the law requires including without limitation, genetic counseling: * Testing may be performed at QDx Pathology Services.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.qdxpath.com

T128353 SITE _____ NAME _____ (repeated 20 times)

MICROBIAL VAGINOSIS

BD AFFIRM VAGINITIS PANEL - Trichomonas Vaginalis, Candida Species, Gardnerella Vaginalis
182 AEROBIC VAGINITIS PANEL - Group B Streptococcus, Staphylococcus aureus, Escherichia eoli, Enterococcus faecalis
166 BACTERIAL VAGINOSIS PANEL - Atopobium vaginae, Bacterial Vaginosis Associated Bacteria 2, Gardnerella vaginalis, Megasphaera species (Types 1&2) with Lactobacillus Profiling by qPCR
560 CANDIDA VAGINITIS PANEL - Candida albicans, Candida glabrata, Candida parapsilosis, Candida tropicalis

Notifier(s):

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non coverage (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Laboratory Tests	Reason Medicare May Not Pay	Estimated Costs

What you need to do now:

- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading
- Choose an option below about whether to receive the checked items listed in the first box above

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1**: I want the Laboratory Test(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2:** I want the Laboratory Test(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3:** I do not want the Laboratory Test(s) listed above, I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date: