

RPS Use Only

Accession #: _____

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME		FIRST NAME		MI	Collection Date ____/____/____		Collection Time ____ AM ____ PM		
DOB ____/____/____		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PT. ID# / ADDITIONAL INFO		PROVIDER: _____ (First, Last, MI)			
SSN ____-____-____		BILL TO: <input type="checkbox"/> RPS Client Account <input type="checkbox"/> Patient Insurance		PT. PHONE ____/____/____		ACCOUNT NUMBER _____			
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED					ACCOUNT NAME _____				
GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)				PHONE NUMBER		STREET ADDRESS OR PO BOX _____			
ADDRESS		CITY		STATE	ZIP		CITY _____ STATE _____ ZIP CODE _____		
PRIMARY INSURANCE <input type="checkbox"/> MEDICARE IN-PATIENT <input type="checkbox"/> MEDICARE OUT-PATIENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> INSURANCE				INSURANCE COMPANY		PHONE NUMBER		PHONE NUMBER _____ FAX NUMBER _____	
POLICY ID#		GROUP ID#		INSURANCE COMPANY ADDRESS		CITY		STATE	
EFFECTIVE DATE ____/____/____		INSURANCE COMPANY ADDRESS		CITY		STATE	ZIP		
DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)					SECONDARY / TERTIARY INS - ATTACH INFORMATION				
ICD-10 #1	ICD-10 #2		ICD-10 #3		<input type="checkbox"/> ABN ATTACHED <input type="checkbox"/> PRIOR AUTHORIZATION ATTACHED				

NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. FOR MORE INFORMATION SEE reglab.org/billingcompliance/

NOTICE: Additional reference laboratory testing may be required at the discretion of the pathologist to establish or confirm a diagnosis. If additional testing is needed the client or patient may receive an invoice for additional testing from the reference laboratory. Check the box if additional reference laboratory testing is not desired. Please note that a definitive diagnosis may not be possible.

<p align="center">CYTOLOGY</p> <p align="center">CERVICOVAGINAL</p> <p>ACOG Age-Based Ordering</p> <p><input type="checkbox"/> Age 21-29 Liquid-based Pap, screen with reflex to HPV High Risk Panel w/ 16 & 18 Genotyping if ASCUS</p> <p><input type="checkbox"/> Age 30-65 Liquid-based Pap, screen and HPV High Risk Panel w/ 16 & 18 Genotyping</p> <p>Individual Testing</p> <p><input type="checkbox"/> Liquid-based Pap, screen</p> <p><input type="checkbox"/> Liquid-based Pap, screen <u>with reflex</u> to HPV High Risk Panel w/ 16 & 18 Genotyping if ASCUS</p> <p><input type="checkbox"/> Liquid-based Pap, screen <u>and</u> HPV High Risk Panel w/ 16 & 18 Genotyping if ASCUS</p> <p><input type="checkbox"/> Liquid-based Pap, diagnostic</p> <p><input type="checkbox"/> Liquid-based Pap, diagnostic <u>with reflex</u> to HPV High Risk Panel w/ 16 & 18 Genotyping</p> <p><input type="checkbox"/> Liquid-based Pap, diagnostic <u>and</u> HPV High Risk Panel w/ 16 & 18 Genotyping</p> <p><input type="checkbox"/> HPV High Risk Panel w/ 16 & 18 Genotyping (HPVSP/HPVTP)</p> <p>Date of LMP: ____/____/____</p> <p>Source: Cervical Cervical/Vaginal Vaginal</p> <p>Patient History (Check all that apply):</p> <table border="0"> <tr> <td><input type="checkbox"/> Postmenopausal</td> <td><input type="checkbox"/> Pregnant</td> </tr> <tr> <td><input type="checkbox"/> Abnormal Bleeding</td> <td><input type="checkbox"/> Postpartum (last 6 weeks)</td> </tr> <tr> <td><input type="checkbox"/> Depo-Provera</td> <td><input type="checkbox"/> Prior Chemotherapy</td> </tr> <tr> <td><input type="checkbox"/> Intrauterine Device</td> <td><input type="checkbox"/> Prior Pelvic Radiation</td> </tr> <tr> <td><input type="checkbox"/> Oral Contraceptives</td> <td><input type="checkbox"/> Hormone Replacement</td> </tr> <tr> <td><input type="checkbox"/> Previous Dysplasia or Malignancy</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Previous GYN Surgery: Specify _____</td> <td></td> </tr> </table> <p>Previous Abnormal Pap Smear: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____</p> <p>Dx: _____</p> <p align="center">NON-GYN CYTOLOGY</p> <p><input type="checkbox"/> Urine (voided) <input type="checkbox"/> Urine (Cath) <input type="checkbox"/> Peritoneal Fluid</p> <p><input type="checkbox"/> Pleural Fluid <input type="checkbox"/> CSF <input type="checkbox"/> Body Fluid Other _____</p> <p><input type="checkbox"/> FNA Smears/Site: _____</p>	<input type="checkbox"/> Postmenopausal	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Postpartum (last 6 weeks)	<input type="checkbox"/> Depo-Provera	<input type="checkbox"/> Prior Chemotherapy	<input type="checkbox"/> Intrauterine Device	<input type="checkbox"/> Prior Pelvic Radiation	<input type="checkbox"/> Oral Contraceptives	<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Previous Dysplasia or Malignancy		<input type="checkbox"/> Previous GYN Surgery: Specify _____		<p align="center">SURGICAL PATHOLOGY</p> <p align="center">BIOPSY</p> <p><input type="checkbox"/> Biopsy / source _____</p> <p><input type="checkbox"/> Biopsy / multiple tissues (list source for each specimen)</p> <p>A _____ B _____</p> <p>C _____ D _____</p> <p><input type="checkbox"/> Biopsy/Renal (incl: light microscopy, immunofluorescence, & electron microscopy)</p> <p><input type="checkbox"/> Biopsy / Nerve</p> <p><input type="checkbox"/> Biopsy / Muscle</p> <p align="center">CONSULTATION</p> <p><input type="checkbox"/> Consultation: <input type="checkbox"/> Slide(s) <input type="checkbox"/> Blocks <input type="checkbox"/> Tissue (attach copy of surgical report)</p> <p><input type="checkbox"/> 2nd Opinion Consultation Source: _____</p> <p>Submitters Case # _____</p> <p align="center">DERMATOPATHOLOGY</p> <p><input type="checkbox"/> Biopsy: source of tissue: _____</p> <p><input type="checkbox"/> Consultation: <input type="checkbox"/> Slide(s) <input type="checkbox"/> Blocks <input type="checkbox"/> Tissue - Source: _____</p> <p><input type="checkbox"/> 2nd Opinion Consultation (Please attach copy of surgical report)</p> <p><input type="checkbox"/> Direct Immunofluorescence</p> <p align="center">BREAST PATHOLOGY</p> <p><input type="checkbox"/> ERA/PRA Immunoperoxidase</p> <p><input type="checkbox"/> ERA/PRA, HER-2/neu, Ki-67 Immunoperoxidase</p> <p><input type="checkbox"/> HER-2/neu Immunoperoxidase</p> <p><input type="checkbox"/> HER-2/neu FISH only</p> <p><input type="checkbox"/> Add Reflex HER-2/neu FISH (Please attach copy of surgical pathology report for all FISH requests)</p> <p align="center">SURGICAL PATHOLOGY REQUIRED INFORMATION</p> <p>Clinical History: _____</p> <p>PreOp Dx: _____</p> <p>PostOp Dx: _____</p> <p>Procedure: _____</p> <p>Complete History and Physical Required</p>
<input type="checkbox"/> Postmenopausal	<input type="checkbox"/> Pregnant														
<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Postpartum (last 6 weeks)														
<input type="checkbox"/> Depo-Provera	<input type="checkbox"/> Prior Chemotherapy														
<input type="checkbox"/> Intrauterine Device	<input type="checkbox"/> Prior Pelvic Radiation														
<input type="checkbox"/> Oral Contraceptives	<input type="checkbox"/> Hormone Replacement														
<input type="checkbox"/> Previous Dysplasia or Malignancy															
<input type="checkbox"/> Previous GYN Surgery: Specify _____															



Specialty Testing Requirements

Clinical Information REQUIRED

Clinical information should be provided. This includes age, gender, clinical diagnosis, clinical history, and previous pathology report

Renal Biopsy

Collect: Tissue.

For light microscopy, submit in 10% buffered formalin. For Immunofluorescence, submit in Zeus fixative. For electron microscopy, submit in 2.5% Millonig's Paraformaldehyde glutaraldehyde fixative.

Collect representative tissue, keeping the tissue wet at all times. Tissue should be handled immediately after excision and submerged in chilled electron microscopy fixative. Avoid crush artifact.

Storage/Transport Temperature: Keep kit refrigerated upon receipt and during transport.

Renal biopsy kits are available that contain fixatives for LM, IF, and EM and include a laboratory requisition form, the lab form requires all necessary patient information and has a detailed protocol for submission of specimens on the back of the form; a pre-paid overnight mailing label, mailing box, refrigerant cool packs, and a biohazard zip-lock transport bag. Request forms and kits from Regional Pathology Services. Please order as needed. The kits have a 3 month shelf life. Material Safety Data are available upon request.

Nerve Biopsy

Collect: Biopsy of nerve tissue.

Specimen Preparation: Fix a segment of tissue in MPG fixative for electron microscopy and a segment of tissue in formalin for tissue embedding.

Storage/Transport Temperature: Transport fixed with sufficient ice or cool packs to keep the specimen cold but without the chance of freezing.

Muscle Biopsy

Collect:

Muscle tissue for enzyme histochemistry: Send frozen tissue on dry ice. Refer to online test directory for further instructions on the freezing process.

Neuropathology Lab 402-559-5194.

Muscle tissue for electron microscopy: Fix tissue immediately in MPG.

Tissue for paraffin embedding: Send separate tissue in formalin.

Storage/Transport Temperature: Transport frozen tissue on dry ice using overnight mailing service. Transport formalin fixed and MPG fixed tissue at room temperature.

Clinical Information REQUIRED: Clinical information should be provided. This includes age, gender, clinical diagnosis, clinical history, neurologic examination, associated diseases, family history, EMG and nerve conduction data. CPK levels, and the site of the muscle biopsy.

Testing Supplies

Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.

Supplies are ordered online at reglab.org/customer-service/supply-orders/ testing supplies and log-on information may be obtained by calling Client Services

Toll Free 800-334-0459

Phone 402-559-6420

Courier Services

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call

Client Services Toll Free 800-334-0459

Phone 402-559-6420

If shipping specimens address to:

UNMC Shipping & Receiving Dock

Regional Pathology Services UT 3314

University of Nebraska Medical Center

601 Saddle Creek Road

Omaha, NE 68106-1180

Transport Instructions:

Specimen Handling/Shipping

To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at reglab.org for more information.

Questions?

Contact client services at 800-334-0459