University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
981180 Nebraska Medical Center
Omaha, Nebraska 68198-1180
www.reglab.org

Toll Free: 1.800.334.0459
Phone: 402.559.6420
FAX: 402.559.9497

Cilia Electron Microscopy Test Request Form

RPS Use Only
Accession #: ______________________

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME | FIRST NAME | MI

DOB / / | GENDER ☐ MALE ☐ FEMALE | PT. ID# / ADDITIONAL INFO

SSN - - | BILL ☐ OFFICE/CLIENT ☐ PATIENT INSURANCE

Collection Date ____/____/____ **Collection Time** ______ **AM PM**

PROVIDER: ______________________________
(First, Last, MI)

PATIENT INSURANCE
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

GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)

ADDRESS | CITY | STATE | ZIP

PRIMARY INSURANCE
☐ **MEDICARE IN-PATIENT** ☐ **MEDICARE OUT-PATIENT** ☐ **MEDICAID** ☐ **INSURANCE**

POLICY ID# | **GROUP ID#**

INSURANCE COMPANY | PHONE NUMBER

INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP

EFFECTIVE DATE / /

DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)

ICD-10 #1 | ICD-10 #2 | ICD-10 #3

SECONDARY / TERTIARY INS – ATTACH INFORMATION

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/**

☐ ABN ATTACHED
☐ PRIOR AUTHORIZATION ATTACHED

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.

EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER
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Cilia Electron Microscopy Test Request Form
(Specimen Collection/Submission protocol – see back of form)

Ciliary Electron Micoscopy

SPECIMEN FIXATIVE

___ EM FIXATIVE
___ 2.5%-3% GLUTARALDEHYDE
___ OTHER *(Please call before submitting)*

Specimen Type

	CILIARY BRUSHING
	TRACHEA
	OTHER

MEDICAL HISTORY

	Chronic/recurrent sinusitis
	Chronic/recurrent otitis
	Chronic/recurrent bronchitis
	Infertility
	Family history of chronic upper/lower respiratory infections
	Family history of known primary ciliary dyskinesia
	Situs inversus/dextrocardia
	Results of cilia beating studies (if performed) ______________
	Results of saccharine testing (if performed) ______________
	Results of prior genetic testing (i.e. DNAH11, if performed) ______________
	Other pertinent information ______________

Pathologists Contact Information
Dr. Kirk Foster 1-402-559-8412 or Dr. Geoffrey Talmon 1-402-559-4793

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