WOMEN'S HEALTH REQUISITION

Advanta Analytical Laboratories
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INSTRUCTIONS

1. **Please PRINT CLEARLY to ensure proper processing.**
2. **Provide all primary/secondary insurance information; or attach copies of patient insurance cards (front and back) on a separate sheet appended to this form.**
3. **Once available, test results can be retrieved through your Advanta Physician Portal. Please email results@aalabs.com for other delivery options.**

PATIENT INFORMATION *(REQUIRED)*

LAST NAME | FIRST NAME | MIDDLE INITIAL | PATIENT ACCOUNT NO.

STREET ADDRESS | CITY | STATE | ZIP CODE | ☐ Male ☐ Female

COLLECTION DATE | DATE OF BIRTH | GENDER

RACE/ETHNIC IDENTIFICATION

☐ **African - American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Jewish - Ashkenazi** ☐ **Jewish - Sephardic** ☐ **Native American** ☐ **Other:** _____

PATIENT INSURANCE INFORMATION

Where applicable, please include a photocopy of insurance card(s) (both sides). For Self Pay, please include a photocopy of a valid driver's license and phone number.

PLEASE SELECT A BILLING OPTION & COMPLETE THE INFORMATION BELOW:

☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ☐ **Self Pay** ☐ **Institution** ☐ **Information Attached**

CERVICAL CANCER SCREENING CYTOLOGY/HPV

CYTOLOGY SPECIMEN SOURCE:

☐ **Cervical** ☐ **Vaginal** ☐ **Other**

GYNECOLOGIC CYTOLOGY CLINICAL HISTORY

CHECK ALL THAT APPLY:

☐ **High Risk of Cervical Cancer**
☐ **Hormone Therapy**
☐ **HX of Abnormality**
☐ **Hysterectomy**
☐ **IUD/DES/BCP'S/DEPO**
☐ **Postmenopausal**
☐ **Post Partum** _____ **wks**
☐ **Pregnant** _____ **wks**
☐ **Routine Test**
☐ **Screening Pap**
☐ **Signs of Medical Necessity**

LMP: _____ **Previous PAP Date:** _____

SELECT A TEST:

☐ **ThinPrep® Pap Test**
☐ **ThinPrep® Pap Test w/reflex to high risk HPV**
☐ **ThinPrep® Pap Test w/reflex to high risk HPV with CT/NG**
☐ **ThinPrep® Pap Test w/high-risk HPV co-testing**
☐ **ThinPrep® Pap Test w/high-risk HPV co-testing and CT/NG**

PRENATAL/PRECONCEPTION

CARRIER SCREENING:

x 1-4 mL EDTA purple top tube ☐ **Cystic Fibrosis**

MOLECULAR INFECTIOUS DISEASE PANELS

SPECIMEN SOURCE: ☐ **Cervical** ☐ **Vaginal** ☐ **Other**

SPECIMEN TYPE: ☐ **BD Eswab** ☐ **ThinPrep®**

☐	**Bacterial Vaginosis Assay:**	**PB** *(Prevotella bivia)* **AV** *(Atopobium vaginae)* **MC** *(Mobiluncus curtisii)* **MM** *(Mobiluncus mulieris)* **GV** *(Gardnerella vaginalis)* **BF** *(Bacteroides fragilis)*
☐	**Candida Plus Assay:**	**CA** *(Candida albicans)* **CD** *(Candida dubliniensis)* **CG** *(Candida glabrata)* **CK** *(Candida krusei)* **CP** *(Candida parapsilosis)* **CT** *(Candida tropicalis)*
☐	**HSV Assay:**	**HSV-1** *(Herpes Simplex Virus, Type 1)* **HSV-2** *(Herpes Simplex Virus, Type 2)*
☐	**STD-3 Assay:**	**CT** *(Chlamydia trachomatis)* **NG** *(Neisseria gonorrhoeae)* **TV** *(Trichomonas vaginalis)*
☐	**STD-Extended Panel:**	**CT** *(Chlamydia trachomatis)* **NG** *(Neisseria gonorrhoeae)* **TV** *(Trichomonas vaginalis)* **MG** *(Mycoplasma genitalium)* **MH** *(Mycoplasma hominis)* **UP** *(Ureaplasma parvum)* **UU** *(Ureaplasma urealyticum)*

TISSUE PATHOLOGY AND NON-GYN CYTOLOGY

MATERIALS SUBMITTED:

☐ **Histology (Tissue)** ☐ **Cytology (Fluid)**

CLINICAL HISTORY:

_____
PERTINENT CLINICAL HISTORY AND FINDINGS

_____
CLINICAL DIFFERENTIAL DIAGNOSIS

1. **Procedure** _____ **Anatomic Site:** _____
2. **Procedure** _____ **Anatomic Site:** _____
3. **Procedure** _____ **Anatomic Site:** _____
4. **Procedure** _____ **Anatomic Site:** _____

ICD-10 CODE(S) *(REQUIRED)*

_____
SELECT ICD-10 FROM OPTIONS OR ENTER ABOVE
(Attach Chart Notes if available)

PHYSICIAN AUTHORIZATION *(REQUIRED)*

_____
PHYSICIAN NAME (PRINTED)

_____
PHYSICIAN SIGNATURE

PATIENT CONSENT

REIMBURSEMENT: Advanta Analytical Laboratories (AAL) will make every reasonable effort to obtain reimbursement for the ordered tests above. I hereby authorize AAL to release to Medicare and/or any insurance carrier providing medical benefits to me and any health plan to which I am a member any and all medical or other information necessary for claims processing. I hereby authorize payment of medical insurance benefits to the party who bills for these claims and accepts assignments. I understand that if my insurance company pays me directly for the services provided by AAL that I am responsible for forwarding such payment to AAL. I understand that I am responsible for deductibles/co-payments as required by my plan.

INFORMED CONSENT OF GENETIC INFORMATION: I hereby authorize follow-up of any testing requested to be performed to verify the outcome and/or accuracy of testing. I authorize the specimens taken from me to be retained by Advanta Analytical Laboratories for testing validation and test development and/or quality control/quality assurance purposes. I authorize tissue samples taken from me to be made available to educational institutions, other physicians and/or scientists and companies engaged in research. I understand that samples may be used in or lead to the development of medical products, processes or other items and such products may be used for commercial purposes. I specifically understand and consent to such uses and understand and agree that I will not receive any compensation for such uses nor will I have any financial, property, ownership, licensing or other interest in any products, processes, intellectual property or other outcomes which may result from research utilizing my tissue sample.

PATIENT NAME *(please print)* | PATIENT SIGNATURE | DATE

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