UFHealth
PATHOLOGY LABORATORIES

ALL ORANGE AREAS ARE REQUIRED.

NON-GYN CYTOLOGY REQUISITION

Patient information*

Name (last, first, middle initial): Sex: Male Female
____

Date of birth (MM/DD/YYYY): ______________________________

Medical record/Patient ID#: ______________________________

Place of service:

- ☐ Hospital inpatient ☐ Ambulatory surgical center
- ☐ Hospital outpatient ☐ Office/Non-hospital

Billing information*

☐ Bill to insurance (MUST include copies of the patient's demographics sheet and insurance ID cards front and back, if not filling-in the requested information below)

☐ Bill facility

Carrier name: ______________________________

Carrier phone #: ______________________________

Carrier address: ______________________________

Policy #: ______________________________

Group plan #: ______________________________

Name of insured (if not same as patient): ______________________________

Date of birth of insured: ______________________________

Relationship of insured to patient: ______________________________

☐ Secondary insurance exists (If checked, you MUST include secondary insurance information on a separate sheet.)

Provider information

Ordering physician: ______________________________

Phone: ______________ Fax: ______________

Ordering physician NPI #: ______________________________

Duplicate report sent to: ______________________________

Duplicate report fax: ______________________________

Clinical history narrative/Clinical question*:

*An Advance Beneficiary Notice of Noncoverage form must be completed and attached for all Medicare patients.

ICD-10 code: ______________________________

Date of procedure: ______________ Time: ____:____ A.M./P.M.

Non-GYN cytology

Body fluid: ☐ CSF ☐ Pleural ☐ Peritoneal ☐ Other (specify below*)

FNA (specify site): ______________________________

Lung BAL/Brushing (specify lobe): ______________________________

Brushing (other): ______________________________

*Other (specify): ______________________________

Thyroid cytology

Thyroid: ☐ Right lobe ☐ Left lobe ☐ Isthmus

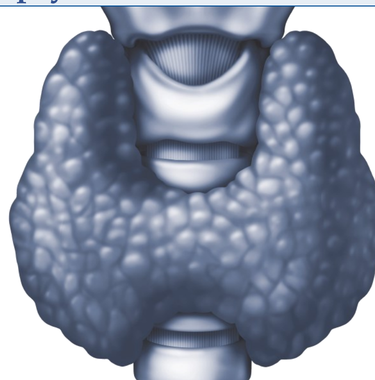
☐ Upper pole ☐ Mid ☐ Lower pole

Ultrasound findings: ☐ Hypoechoic (solid) ☐ Cystic ☐ Solid/Cystic (complex)

☐ Hypervascular ☐ Microcalcifications ☐ Irregular borders ☐ Solitary

☐ Heterogeneous ☐ Increased in size Size: ______________ cm

Point to biopsy site below



☐ Perform thyroid molecular assay for indeterminate or reflexive results

Urine cytology

☐ Voided ☐ Bladder washing ☐ Other: ______________________________

☐ Reflex urine to UroVysion™ (if atypical/suspicious/positive)

Molecular/Cytogenetics testing

UroVysion™/Urine FISH

☐ UroVysion™ with cytology ☐ UroVysion™ only

Lung carcinoma/Other

☐ Next-generation sequencing (NGS)

☐ ALK FISH (FDA-approved) ☐ EGFR mutation

If EGFR/ALK are negative: ☐ Reflex ROS1 FISH ☐ ROS1 FISH

Flow cytometry

☐ Perform immunophenotyping (flow cytometry) on specimen*

*Submit specimens in RPMI medium.

TESTING AUTHORIZATION:
I authorize for payment to be made to University of Florida Health Pathology Laboratories for any services furnished by them and also for UF to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to these services. If my health insurance plan will not direct payment to UF, I agree to forward UF all payments received for their services. I also authorize UF or any holder of information about me to release to my health insurance plan such information needed to adjudicate their claim.

Patient signature: ______________________________ Date: __________

NOTICE TO ORDERING PHYSICIAN:
We respectfully ask that you authenticate your order for the pathologic examination of the accompanying specimen(s) by personally signing this requisition in the space provided or by initialling next to your printed name. If your signature (or initials) are not affixed hereto, you attest that you have caused the subject patient's medical record to include a specific reference (i.e., order) to your intent that the accompanying specimen(s) be examined by a pathologist and that you have personally signed (handwritten or electronic) said reference (i.e., order) in the subject patient's medical record.

Physician signature: ______________________________ Date: __________

Name of person completing form: ______________________________

http://pathlabs.ufl.edu

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