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HEALTHLINK LABORATORY SERVICES

Northeast Georgia Health System, INC
743 Spring NE Gainesville, GA 30505 770-219-7828
Dr. E. Joseph Conway, Laboratory Director

Patient Information

Last Name	First Name	Middle Initial	Ordering Physician
Street	City	State Zip	Account Name (Practice/Clinic)
Date of Birth	( ) Male ( ) Female	Social Security #	Phone
			( ) BILL INS ( ) BILL M/M ( ) BILL PATIENT ( ) BILL ACCOUNT

Insurance Information

Insured Name	Relationship	Insurance Company
Group Name		Phone (With Area Code)
Insurance Company Address	City	State ZIP

Group/Policy #	Authorization #	Insurance ID #	Medicare #	Medicaid #

Surgical Information:

Collection Date:

Time specimen removed from patient:

Time specimen placed in 10% formalin:

Site of tissue removal (be specific):

Surgical Procedure performed:

Specimen (list each specimen and their source)

1

2

3

4

Previous History

( ) carcinoma ( ) giloma
( ) sarcoma ( ) menigioma
( ) melanoma ( ) germ cell tumor
( ) hodgkin's lymphoma ( ) non- hodgkin's lymphoma
( ) other : _____

Suture Orientation: _____

Is marker in tissue ? If so, where? _____

Pre-op diagnosis: _____

Post -op diagnosis: _____

( ) chemotherapy, last date: _____

( ) radiation, last date : _____

( ) previous biopsy/resection, date: _____

BIRADS SCORE: _____

Cytology Information

Collection Date : Date Received:

Nongynecological Test Data:
( ) urine: ( ) voided ( ) catherized ( ) bladder washing
( ) breast ( ) left ( ) right ( )cyst fluid ( ) nipple discharge
( ) sputum
( ) fine needle aspirate : (source) _____

( ) Tzank smear: (source) _____

LAB USE ONLY
___ml fresh/fixed _____color ( ) TP ( ) CB

_____ pre-prepared smears

Gynecological Test Data:
Source: ( ) cervical ( ) vaginal
( ) ThinPrep Pap Test
( ) ThinPrep Pap with reflex HR HPV
( ) CO test HR HPV
( ) CO test HR HPV with reflex Genotyping 16/18/45
( ) Conventional Pap Smear: # of slides _____

The following test can be added to the Thinprep Pap test;
A Pap test will not be performed unless ordered
( ) HPV, High Risk Only ( ) chlamydia/gonorrhea

Patient History:
( ) normal cycle ( ) irregular cycle ( ) pregnant **LMP** _____
( ) perimenopausal ( ) postmenopausal
( ) hysterectomy; uterus & cervix ( ) supracervical
( ) estrogen; replacement therapy ( ) IUD
( ) biopsy: date: _____

( ) colposcopy : date _____ ( ) cryosurgery; date _____
( ) cone/leep; date _____

( ) previous abnormal pap; diagnosis & date _____

Previous pap #_____Date_____

Waiver of Liability for Pap Smear Screening MUST BE COMPLETED FOR ALL MEDICARE BENEFICIARIES.
I have been notified by my physician that he or she believes that, in my case, Medicare ilikely to deny payment of the pap smear which I am having taken today because Medicare pays for only **one routine pap smear screening every two years or one every year for high risk patients.** If Medicare denies payment, I agree to pay the laboratory for my routine pap screening.
Medicare Beneficiary
Signature_____ Date_____

Specify reason for service/ICD10 C
1 2

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