	FOR LAB USE ONLY:
ACCT.#	



none: (850) 416-2940	Pathology	Doquiciti
ours: Mon - Fri, 7:00a - 5:30p	Pathology	requisiti

ALL HIGHLIGHTED AREAS ARE REQUIRED TO BE A VALID ORDER ALL HIGHLIGHTED AREAS ARE REQUIRED TO BE A VALID ORDER	
ALL HIGHLIGHTED AREAS ARE REQUIRED TO BE A VALID ORDER Collected By (First & Last Name): Date Collected: Time Collected: Date Col	
RDER DATE:	
Collected By (First & Last Name): Date Collected: Time Collected:	
Date Collected:	
PROVIDER'S FULL NAME	AM / PM
First Firs	
DRESS:	MI
Surance Carrier: Self Other:	
Self Other:	
Provider's Phone #:	MI
Pathology Tissue Request Specimen Collection Date & Time: Specimen Sources Specimen Collection Date & Time: Specimen Sources Conventional Liquid Prep with Reflex HPV EDC by Dates/Exam: Specimen Collection Date & Liquid Prep with HPV Specimen Collection Conventional Liquid Prep with HPV Sustainal Conventional Conventional Conventi	
Surance Authorization #:	
Ascension Sacred Heart Pensacola -	
7800 US-98 Pensacola, FL 32504 Phone: (850) 416-7000 Phone: (850) 278-3000 Phone: (850) 278-3000 Phone: (850) 416-7000 Phone: (850) 278-3000 Phone: (850) 769-1511 Phone: (850)	
Pensacola, FL 32504	
When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnos of a patient, rather than for screening purposes. In the event that Ascension Sacred Heart Laboratory cannot perform a test ordered, a Reference Lab will be utilized. The Reference Lab will bill directly for test code. DIAGNOSIS CODE	
DIAGNOSIS CODE Pathology Tissue Request Pathology Gyn Request Specimen Priority: Routine STAT Specimen Collection Date & Time: Clinical History/Dx: LMP: MM DD YYYY Specimen Source: Cervical Endocervical Vaginal Type: Conventional Liquid Prep with HPV Liquid Prep with HPV	
Pathology Tissue Request Pathology Gyn Request P	
CODE □ Pathology Tissue Request □ Pathology Gyn Request Specimen Priority: □ Routine □ STAT Specimen Collection Date & Time: □ Clinical History/Dx: □ LMP: □ MM □ DD □ YYYY Pre Op: □ LMP: □ MM □ DD □ YYYY Specimen Source: □ Cervical □ Endocervical □ Vaginal □ Pathology Placenta Request □ Type: □ Conventional □ Liquid Prep with Reflex HPV EDC by Dates/Exam: □ Liquid Prep with HPV	AGNOSIS
Specimen Priority: Routine STAT Specimen Collection Date & Time: Clinical History/Dx: LMP: MM DD YYYY Post Op: Specimen Source: Cervical Endocervical Vaginal Pathology Placenta Request	CODE
Specimen Collection Date & Time: Clinical History/Dx: Pre Op: LMP: MM DD YYYY Post Op: Specimen Source: Cervical Endocervical Vaginal Pathology Placenta Request EDC by Dates/Exam: Liquid Prep with Reflex HPV Liquid Prep Liquid Prep with HPV	
Pre Op:	
Post Op: Specimen Source: _Cervical _Endocervical _Vaginal _Type: _Conventional _Liquid Prep with Reflex HPV _Liquid Prep with HPV	
□ Pathology Placenta Request EDC by Dates/Exam: Type: □ Conventional □ Liquid Prep with Reflex HPV □ Liquid Prep □ Liquid Prep with HPV	
EDC by Dates/Exam: Liquid Prep Liquid Prep with HPV	
EDC by Dates/Exam: Liquid Prep Liquid Prep with HPV	
Birthweight: Hormones: \(\triangle \tri	
Infant ADC ADS	
Infant APGARS: Postpartum: ☐ YES ☐ No	
Delivery Date: Hysterectomy: \(\subseteq YES \) \(\subseteq No \)	
Reason for Exam: Pregnant: DYES No	
Postmenopausal: ☐ YES ☐ No	
☐ Pathology Breast Request ☐ Pathology Non-Gyn Request	
Ischemic Time: Specimen Collection Date & Time:	
Time in Formalin: Clinical History/Dx:	
Specimen Type	
Specimens Source:	
A:	
B: Aspirate, Site:	
C: Bronchial Alveolar Lavage	
D: Breast Cyst Fluid/Nipple Discharge	
E: Bronchial Brushing	
F: Bronchial Washing	
G: Cerebrospinal Fluid	
H: FNA, Site:	
I.	
J:	
K: Sputum	
L: Urine	
Urine for Ploidy	
Washing, Site:	
Other:	

AGENCY OR FACILITY:

	FOR LAB USE ONLY:
ACCT.#	



Scheduling:

Phone: (850) 416-2940
Hours: Mon - Fri, 7:00a - 5:30p
Lab Order Fax Server: (850) 416-7337

	AGENCY OR FACILITY:	
FACILITY ADDRESS:		
DIRECT PHONE #: (
	SPECIMEN	
Collected By (First & La		
Date Collected:	Time Collected:	AM / PM
'S FULL NAME:		
Last	First	MI
'S SIGNATURE:		
ovider:	First	MI
hone #: () -	11134	
Report To:	☐ Critical Report:	
<u> </u>	Phone #:	
nsion Sacred Heart Bay –	☐ Ascension Sacred Heart Gulf	-
N Bonita Ave A ma City, FL 32401	3801 US-98 Port St. Joe, FL 32456	
e: (850) 769-1511	Phone: (850) 229-5600	
	ts that are medically necessary for the diag ilized. The Reference Lab will bill directly fo	
ordered, a reference Edd will be del	inzed. The reference Edb will bill directly lo	DIAGNOSIS
ology Cym Dogyogt		CODE
ology Gyn Request	e:	
History/Dx: DD		
en Source: 🗌 Cervical 🗎		
	iguid Prep with Reflex HPV	
☐ Liquid Prep ☐ L	•	
Liquiu Flep	Iquiu Flep Witti FTV	
nes: \(\sum \text{YES}	□ No	
rtum: TES	□No	

Phone: (850) 416-2940 Hours: Mon - Fri, 7:00a - 5:30p	sition	DIRECT PHONE #: (_		
ab Order Fax Server: (850) 416-7337 ALL HIGHLIGHTED AREAS REQUIRED TO BE A VALID O			SPECIMEN	
ORDER DATE:/	RDER	Collected By (First & L	· · · · · · · · · · · · · · · · · · ·	
PATIENT'S FULL NAME: Last First N	AI .	Date Collected:	Time Collected:	AM / PM
DOB:/ SSN:		S FULL NAME:		
PHONE #: () SEX: M F	ROVIDER	Las	t First	MI
ADDRESS:	PROVIDER'	S SIGNATURE:		
nsurance Carrier:	Copy to Prov	vider: Last	First	MI
Policy #:Group #:	Provider's Ph	none #: ()		
Guarantor: ☐ Self ☐ Other:	· □ Fax	Report To:	☐ Critical Report:	
OOB:/ Relationship: Phone #: ()			Phone #:	
nsurance Authorization #: Exp. Date://			Thone in	
☐ Ascension Sacred Heart Pensacola - ☐ Ascension Sacred Heart Emerald Coast -		sion Sacred Heart Bay –	Ascension Sacred Heart Gul	f -
5151 N Ninth Avenue 7800 US-98 Pensacola, FL 32504 Miramar Beach, FL 32550		Bonita Ave A na City, FL 32401	3801 US-98 Port St. Joe, FL 32456	
Phone: (850) 416-7000 Phone: (850) 278-3000	Phone	: (850) 769-1511	Phone: (850) 229-5600	
When ordering tests for which Medicare reimbursement will be sought, physicians (or other individual of a patient, rather than for screening purposes. In the event that Ascension Sacred Heart Laboratory of				
DIAGNOS		ruereu, a Reference Lab will be t	idinzed. The Reference Lab will bill directly in	DIAGNOSIS
CODE				CODE
☐ Pathology Tissue Request		ology Gyn Request		
Specimen Priority: ☐ Routine ☐ STAT	'		ne:	
Specimen Collection Date & Time:		**		
Pre Op:		MM DD		
Post Op:			☐ Endocervical ☐ Vaginal	
☐ Pathology Placenta Request	— "		Liquid Prep with Reflex HPV	
EDC by Dates/Exam:		☐ Liquid Prep ☐	Liquid Prep with HPV	
Birthweight:	Hormon	es: \(\sum \text{YES}	□No	
Infant APGARS:	Postpart	um: YES	□No	
Delivery Date:	Hystered	ctomy: \(\sum \text{YES}	□No	
Reason for Exam:	Pregnan	t: \(\sum \text{YES}	□No	
	Postmer	nopausal: 🗌 YES	□No	
☐ Pathology Breast Request	Patho	ology Non-Gyn Reque	st	
Ischemic Time:	Specime	en Collection Date & Tin	ne:	
Time in Formalin:	Clinical I	History/Dx:		
Specimens Source:	Specime	en Type:		
A:	Ascitio	Fluid		
B:	Aspira	te, Site:		
C:	Bronch	nial Alveolar Lavage		
D:	Breast	Cyst Fluid/Nipple Discl	narge	
E:	Bronch	nial Brushing		
F:	Bronch	nial Washing		
G:	Cerebr	ospinal Fluid		
H:		iite:		
l:		Site:	\vdash	
J:	Sputur			
K:	Urine	11		
L:		:D(-:.4		
		or Ploidy		
		ng, Site:		
	Other:			