Specimen Information

___/___/___ Date Collected   ______ Time Collected

Phlebotomist Initials __________

Fasting: ☐ YES ☐ NO

PMH LABORATORY Inc.

"Excellence in Laboratory Medicine"

Cesar A. Rodriguez, M.D. -Laboratory Director
5862 Edinger Ave. Huntington Beach, CA 92649
(562) 592-2890 • Fax (909) 803-9790

SPECIMEN ID #

DATE RECEIVED

PANEL TEST REQUISITION

Patient Information

Patient Last Name

Date of Birth __/__/__

Patient First Name, Middle Initial

Gender ☐ Male ☐ Female

☐ **Uninsured Patient**

Patient Address

City   State   Zipcode

Practice Information

Requesting Provider ____________________

REQUIRED

Bill Type: [ ] Insurance [ ] Medicare [ ] Medi-Cal [ ] Bill Patient
[ ] Bill Doctor [ ] Cash

Diagnostic Code(s)

FAMILY PACT

(HAP) #

SECONDARY ICD-10 DIAGNOSIS REQUIRED

[ ] Z20.2 Contact with/exposure to STD(s)
[ ] Z72.51 High Risk heterosexual behavior
[ ] Z72.51 High Risk homosexual behavior
[ ] Z22.4 Carrier of STD(s)
[ ] Z72.53 High Risk bisexual behavior
[ ] Z86.19 Retest 3 month post treatment CT/GC

FAMILY PACT PROCEDURES (FEMALES):

[ ] Z30.011		[ ] Z30.41 Oral Contraception	
[ ] Z30.016		[ ] Z30.45 Patch	
[ ] Z30.015		[ ] Z30.44 Ring	
[ ] 87389 HIV 1&2	SS	[ ] 87491 CHLAMYDIA	GP/U
[ ] 86780 RPR	SS	[ ] 87591 GONORRHEA	GP/U
[ ] 86593 RPR TITER (Reflex)	SS		

[ ] Z30.430		[ ] Z30.431 IUD	
[ ] 87389 HIV 1&2	SS	[ ] 87491 CHLAMYDIA	GP/U
[ ] 86780 RPR	SS	[ ] 87591 GONORRHEA	GP/U
[ ] 86593 RPR TITER (Reflex)	SS		

[ ] Z30.018		[ ] Z30.49	
[ ] 87389 HIV 1&2	SS	Barrier/Fertility Awareness Method	
[ ] 86780 RPR	SS	[ ] 87491 CHLAMYDIA	GP/U
[ ] 86593 RPR TITER (Reflex)	SS	[ ] 87591 GONORRHEA	GP/U

FAMILY PACT PROCEDURES (MALES):

[ ] Z30.018		[ ] Z30.49	
[ ] 87389 HIV 1&2	SS	*Barrier/Fertility Awareness Method*	
[ ] 86780 RPR	SS	[ ] 87491 CHLAMYDIA	GP/U
[ ] 86593 RPR TITER (Reflex)	SS	[ ] 87591 GONORRHEA	GP/U

PRESUMPTIVE ELIGIBILITY LAB TEST

[ ] 87389 HIV 1&2	SS	[ ] 87491 CHLAMYDIA	GP/U
[ ] 87340 HEPATITIS B SURFACE Ag	SS	[ ] 87591 GONORRHEA	GP/U
[ ] 86780 RPR	SS	[ ] 86593 RPR TITER (Reflex)	SS

CYTOLOGY

[ ] 86142	PAP Smear (Thin Prep, Sure Path)
[ ] 86142	PAP Smear, if ASCUS reflex to HPV
[ ] 86142	PAP Smear, if ASCUS & above reflex to HPV
[ ] 86164	PAP Smear, Conventional (Slide)
[ ] 87624	HPV High Risk
[ ] 87491	Chlamydia RNA Amplification
[ ] 87591	GC RNA Amplification

☐ Vaginal ☐ Cervix ☐ Endocervix

LMP:

BIOPSY/ NON-GYN CYTOLOGY SOURCE

1.__________ 2.__________
3.__________ 4.__________

HISTORY

[ ] Previous Pap Smear __________

[ ] Partial Hysterectomy	[ ] IUD
[ ] Total Hysterectomy	[ ] Pregnant
[ ] Post Menopausal	[ ] Cervicitis
[ ] Spotting/Bleeding	[ ] Post Partum
[ ] Birth Control/Hormones	[ ] Depo Provera
[ ] Other	

HEMATOLOGY

[ ] 85025	CBC w/DIFF	L
[ ] 85018	Hemoglobin	L
[ ] 85014	Hematocrit	L
[ ] Z234.80	2nd Pregnancy Unsp.	
[ ] Z39.2	Post Partum Pregnancy	

I, the undersigned, understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing the authorization, I allow the release of any medical information necessary to process this claim. By signing, I certify that I have provided an unadulterated sample to be analyzed. I acknowledge that the laboratory has permission to release my results directly to the treating physician or facility. PMH Laboratories Inc., also has my permission to outsource the processing of this sample at their discretion. I hereby authorize my insurance benefits to be paid directly to the laboratory for services rendered and I agree to endorse any payments received from my insurer and forward them to the Laboratory for services rendered.

Patient Signature:____________________ Date: __________

I authorize the above ordered laboratory test(s). If no profile is selected. PMH Laboratories Inc., will refer to your custom profile for testing and any additional test you have ordered on this form.

Physician Signature:____________________ Date: __________

PMH LAB Copy -White / Physician Copy - Yellow