

PATIENT INFORMATION			
Last Name		First Name	M.I.
Date of Birth	Sex M F	MR #	
Street Address			Apt. No
City		State	ZIP
Collection Date			
LMP			
★ DOCTOR CLINIC			
Copy to:			
RMPC Log#			

Please attach a copy (front & back) of the patient's insurance card

Billing Information	Specimen Site	Test Requested	Diatherix TEM-PCR 7010	Clinical
<input type="checkbox"/> Medicare (Primary)	<input type="checkbox"/> Cervical/Endocervical	<input type="checkbox"/> Thin Prep (TP) only	<input type="checkbox"/> STD Panel (TP, Swab)	<input type="checkbox"/> Prior abnormal
<input type="checkbox"/> Insurance Bill	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Thin Prep reflex HPV	<input type="checkbox"/> Bacterial Vaginosis (Swab)	<input type="checkbox"/> High Risk
<input type="checkbox"/> Bill Patient (Self Pay)	<input type="checkbox"/> Urine	<input type="checkbox"/> TP w/HPV regardless	<input type="checkbox"/> SSTI Plus (TP, Swab)	<input type="checkbox"/> Hormone Therapy
ICD-10: _____	<input type="checkbox"/> FNA	<input type="checkbox"/> TP w/HPV, 30+yrs	<input type="checkbox"/> GI Panel (Swab, Stool)	<input type="checkbox"/> IUD
Notes to lab:		<input type="checkbox"/> GC/Chlamydia DNA	<input type="checkbox"/> ABRx	<input type="checkbox"/> Post-Partum
_____		<input type="checkbox"/> Reflex HPV Genotype	<input type="checkbox"/> Upper Respiratory (2 Separate Swabs)	<input type="checkbox"/> Pregnant
_____			<input type="checkbox"/> Other _____	<input type="checkbox"/> Post-Menopause
				<input type="checkbox"/> Post-Hysterectomy

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