



TOPA Diagnostics - Women's Health Requisition

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DATE COLLECTED		

REFERRED BY

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BILL INSURANCE BILL PATIENT
 BILL MEDICARE # BILL MEDI-CAL

History / Differential Dx / ICD-10:

Copies to additional physician (print full name):

PATIENT INFORMATION

LAST NAME	FIRST NAME		INITIAL
ADDRESS			
CITY	STATE	ZIP REQUIRED	
AGE	M F SEX	BIRTH DATE	AREA CODE PHONE

(Please send photocopy of insurance card, both sides.)

MEDICAL RECORD # _____

INSURANCE CO. NAME	GROUP NO.
RESPONSIBLE PARTY	POLICY NO.

PATHOLOGY SPECIMENS

Submit in formalin

- 1.
- 2.
- 3.
- 4.
- 5.

GYN CYTOLOGY SPECIMENS

LMP: ____ / ____ / ____

DIAGNOSIS / ICD-10 CODE:

FOR MEDICARE PATIENT WITH NO DIAGNOSIS, PLEASE ATTACH ABN.

Specimen Source: Vaginal Cervical
 Endocervical Conventional Pap

Previous Pap Dx:

Clinical Impression / Pertinent History:

Birth control Hormonal therapy
 Postpartum IUD
 Hysterectomy DES exposure
 Supracervical Chemotherapy
 Pregnant Radiation therapy
 Postmenopausal
 GYN surgeries: _____
 Hx of CA: _____
 Other history: _____

Physician Orders:

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VP-06