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FRANKLIN DIAGNOSTICS

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TEST ORDER/ SPECIMEN REQUISITIION

Highlighted areas required

Facility:____

Ordering physician: ____
Duplicate copy to: ____
Phone: __________________Fax: ______________________________
Duplicate copy to:____
Phone: __________________Fax:_______________________________

GYN SPECIMENS

Specimen Type	Specimen Source:
Thin Prep pap test	Cervical
Conventional pap	Endocervical
HPV test	Vaginal

Reflex to HPV..... on specimen with following (check results):

None ASCUS Low Grade High Grade

Patient Information

Last: ____________________ First:___________________ MI:_____
DOB:____________ Gender: M F
Collection date: _______________ Acc#_____________
Patient address: ____
City, State, Zip:____
Medical record/SS#______________Phone (___)______________
(Insert patient label instead)

Clinical information ICD10

Current GYN Exam findings: _______________________
Prior pap date:_____________________ Normal Abnormal
Postmenopausal Hormone Replacement Therapy
LMP:__________ Oral Contraceptives: Yes No Type_____
History of Malignancy: Yes No Specify: ____________
History of Chemotherapy/ Pelvic Radiation: Yes No
Hysterectomy: Yes No ☐Total ☐ Supra-cervical

Billing Information

☐ Bill insurance ☐ Bill Client ☐ Bill patient

Please attach copy of insurance card and patient Demographic sheet or Driver License

Diagnosis/ ICD 10 Codes

Diagnosis/ICD10 code_______________________
____
____

Clinical information

____
____
____

Non -GYN SPECIMEN

Fine Needle Aspiration
Describe/ Anatomic site__________________
____
Urine Voided/ Catheterized (specify):___________
Effusion Pleural/ Peritoneal (specify) :________
Bronchial Washings / Brushings (specify):_______
Other : specify: _______________________________
Rule out_______________________________________

Specimen Sites	Findings/Clinical Diagnosis
A_________________	_____________________
B_________________	_____________________
C_________________	_____________________
D_________________	_____________________
E_________________	_____________________
F_________________	_____________________
G_________________	_____________________
H_________________	_____________________
I_________________	_____________________
J_________________	_____________________
K_________________	_____________________
L_________________	_____________________

Physician/Provider Signature:____