Request Forms

Pathology/Cytology Request-Inpatient

addressograph

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Pathologist

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PATHOLOGY / CYTOLOGY REQUEST
DECATUR GENERAL HOSPITAL
Decatur, AL

******* TO ACCOMPANY *******

******* SURGICAL SPECIMENS *******

Specimen number: _____
(pathology use only)

clinical data _____

Surgeon: _____ FROZEN SECTION (yes/no) _____

SPECIMEN (pathology requests are not ordered in the computer)	SOURCE	WT (gms)
#1.		
#2.		
#3.		
#4.		
#5.		
#6.		
#7.		
#8.		
#9.		
#10.		

Receptor Studies.....( ) needed.....( ) previously done

Circulating RN: _____ date: _____

Specimen received by: _____

FORM 745-09 2 PRT NCR (REV.)

Decatur General
1201 7th Street, SE, Decatur, AL 35609-2239
Phone: (256) 341-2438 Fax: (256) 584-8210

Surgical Pathology and Cytology Requisition

Patient's Name (Last, First, Initial)

Specimen Date MO DAY YR	Physician	Sex	Age	Person Responsible (Last, First, Initial)
Billing Information ☐ Bill Account ☐ Bill Patient	Street Address City, State, Zip			Street Address City, State, Zip

CHOOSE ☐ Medicare ☐ Medicaid	☐ Champus ☐ Blue Shield	☐ Other	Patient's Soc. Sec. No.	Patient's Date of Birth	Telephone

Insured's ID, Medicare, and/or Medicaid No. (Include any letters) | Other Insurance (Name, Number, Location)

Patient or authorized person's signature — I authorize the release of any medical information necessary to process this claim and request payment of Medicaid/Champus benefits either to myself or the other party who accepts assignment.

Signature: _____ Date: _____

ADVANCE BENEFICIARY NOTICE

Medicare will only pay for the services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare law. Decatur General Hospital believes that your physician is in the best position to know the clinical assessment needs of his/her patients. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for _____ for the following reasons: ☐ Medicare may not pay for this service for the provided diagnosis. ☐ Medicare does not pay for tests that do not have FDA approval. ☐ Medicare usually does not pay for routine exams or laboratory screening procedures. ☐ Other _____ I have been notified by my physician/supplier that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reason(s) stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature: _____ Date: _____

CYTOLOGY REQUEST

☐ Cervical — Vaginal

☐ Vaginal Only

☐ One Slide

☐ Two Slides

☐ Maturation Index

Date LMP _____

Date Menopause _____

Post Menopausal Bleeding ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Post Partum ☐ Yes ☐ No

No. weeks: _____

Leukorrhea ☐ Yes ☐ No

Other _____

Uterine or Pelvic Treament

☐ None ☐ Surgery ☐ Biopsy

☐ Radiation ☐ Hormones ☐ BCP

Give Details _____

Previous Smears _____

Previous Cytology

☐ UNSAT ☐ ASCUS

☐ WNL ☐ HGSIL

☐ Benign Atypia ☐ POS

Date: _____

Specimen# _____

Non-Gyn Source

☐ Bronchial Washing ☐ Urine ☐ Hormone Estimation

☐ Pleural Fluid ☐ Cerebral Spinal Fluid

SURGICAL PATHOLOGY REQUEST

1. Preoperative Diagnosis: _____

2. Post Operative Diagnosis: _____

3. Specimen(s) Submitted: _____

4. Pertinent Clinical Information: _____

Form#736-41 (Rev. 3-00)

Physician Signature _____ Date _____

Transfusion Reaction Investigation Results Report-Side 1 (Lab Use Only)

TRANSFUSION REACTION INVESTIGATION RESULTS REPORT - SIDE 1

Donor Unit Number_____
Type component transfused_____
Patient Identification: Date/Time Samples Received (Post) _____
Date/Time Post Urine Collected_____

Clerical/Technical Investigation Results_____
_____

*** Red Cell Studies ***
Sample *** Anti-sera ***

Sample	A	B	AB	D	Con	Du	Other	AHG Test	ABO & RH Result
Patient Pre-Sample									
Patient Post-Sample									
Donor Segment									

*** Compatibility Testing ***

	SALINE RT	ALBUMIN 37	AHG	Interpretation
Pre-Transfusion Serum with Donor Segment				
Post-Transfusion Serum with Donor Segment				

*** Antibody Screening Results ***

	SALINE RT	ALBUMIN 37	AHG	Interpretation
Pre-Transfusion Serum				
Post-Transfusion Serum				
Donor Segment				

*** Other Blood Test Results ***
Post (5-7 hours) Unconj. Bili_____
Hemolysis_____ Icterus_____
Hemoglobin_____ Hematocrit_____
Referenced Blood Studies_____
Plasma or Serum color_____
Other_____
_____
_____

*** Urine Test Results ***
Free Hemoglobin_____
Intact RBCs_____
Other_____
Donor Segment Culture
Date_____
Gram Stain_____
_____

*** IMPRESSION ***
_____
_____
_____
_____
_____
_____

Pathologist_____
Date_____

Transfusion Reaction Investigation Results Report-Side 2 (Filled Out by Nursing Service)

TRANSFUSION REACTION INVESTIGATION RESULTS REPORT - SIDE 2

Patient Identification:

Date_____ **Time Investigation Begun**_____ **Component**_____
Time Transfusion Started_____ **Time Stopped**_____
Donor Segment Number_____ **Amount of Component Received**_____
Pre-transfusion Temperature_____ **Post-transfusion Temperature**_____
Pre-transfusion Pulse_____ **Post-transfusion Pulse**_____

***** Clinical Signs and Symptoms (check if observed) *****

Chills	_____	**Arthralgia**	_____
Severe Shaking Chills	_____	**Headache**	_____
Severe Low Back Pain	_____	**Skin Pallor**	_____
Hypotension	_____	**Dyspnea**	_____
Nausea	_____	**Chest Pain**	_____
Urticaria	_____	**Generalized Bleeding**	_____
Hematuria	_____	**Shock**	_____
Perspiration	_____		

Other Pertinent Observations, Signs, or Symptoms _____
_____
_____
_____

Transfusionist_____
M.D._____

Previous Transfusion History_____
_____
_____
_____

Diagnosis and Pertinent Medical History (including previous pregnancies)
_____
_____
_____
_____
_____
_____

Other Information or Comments_____
_____
_____
_____

Tech_____
Date_____
Time_____

THERAPEUTIC PHLEBOTOMY DATA SHEET

DATE: _____ **OP #** _____

PATIENT NAME: _____

PHYSICIAN: _____

PRE- PHLEBOTOMY PULSE_____ **B/P**_____ **TECH:**_____

NOTES:_____
_____
_____
_____

TECHNOLOGIST NOTES REGARDING PHLEBOTOMY:

_____
_____
_____
_____

POST-PHLEBOTOMY PULSE_____ **B/P**_____ **TECH:**_____

NOTES:_____
_____
_____
_____

PATIENT INSTRUCTIONS:

1. **HOLD THUMB OVER PHLEBOTOMY SITE BANDAGE FOR 5 MINUTES RAISED ABOVE HEAD.**
2. **SIT ON EDGE OF BED BEFORE GETTING OFF BED. DIZZINESS? IF SO, INSTRUCT PATIENT TO LIE BACK DOWN ON BED.**
3. **INSTRUCT PATIENT TO DRINK FLUIDS TO REPLACE BLOOD VOLUME LOST.**
4. **INSTRUCT PATIENT TO NOT LIFT HEAVY OBJECTS WITH ARM USED FOR 8 HOURS AFTER PHLEBOTOMY.**
5. **INSTRUCT PATIENT TO CALL EMERGENCY ROOM IF COMPLICATIONS OCCUR.**

DECATUR GENERAL HOSPITAL
1201 7TH STREET S.E.
DECATUR, ALABAMA 35602

PATIENT CONSENT FOR THERAPEUTIC PHLEBOTOMY

I_____ have been informed that my physician has ordered that approximately 450 ml of blood be drawn for the purpose of doing a Therapeutic Phlebotomy as part of my treatment. I give my consent for_____ a qualified Medical Technologist to render this treatment understanding that possible complications may occur.

SIGNATURE

WITNESS_____

WITNESS_____

POST ORIGINAL TO PATIENT'S CHART AND A COPY TO BLOOD BANK FILES.