PA Pathology Associates

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OFFICE / FACILITY

PATIENT'S LAST NAME		FIRST NAME	
DATE COLLECT	TIME COLLECT	DOB	SEX
SOCIAL SECURITY # --- ---		PHONE #	
ADDRESS			
CITY, ZIP		PATIENT ID #	

☐ COPY OF INSURANCE CARD ATTACHED (FRONT AND BACK) ☐ BILL PATIENT

PLEASE HAVE MEDICARE PATIENTS READ AND SIGN ADVANCED BENEFICIARY NOTICE (ABN) ON THE BACK OF FORM

SEND DUPLICATE REPORT TO:

DIAGNOSIS:	**ICD-9 CODE(S) OR S-CODE(S):**		

CLINICAL DATA:

GYN CYTOLOGY REQUEST

☐ **PAP ONLY**
(Conventional, SurePath© or ThinPrep©)

☐ **LIQUID BASED PAP WITH REFLEX TO HPV** IF ASCUS**
(Per guidelines: Patients 21 to 65 Years of Age, or Any Age if Indicated)

☐ **LIQUID BASED PAP AND CO-TEST HPV****
(Per guidelines: Patients 30 to 65 Years of Age)

***** These tests have diagnosis, frequency and/or age related coverage limits. Please check with patient's stated insurer before ordering. HPV testing by Roche COBAS 4800 to identify HPV type 16, type 18, and pooled high-risk types.***

Source:
☐ Cervical
☐ Endocervical
☐ Vaginal

LMP

Hormonal Status:
☐ Post Menopausal
☐ Pregnant
☐ Postpartum
☐ BCP
☐ Depo Provera
☐ Hormonal Therapy
☐ IUD
☐ Hysterectomy

☐ **Routine Screening**

☐ **High Risk Screening – Please Indicate:**
☐ Post Menopausal Bleeding
☐ 7 yrs or more since last screening
☐ Abnormal Gyn exam
☐ DES Exposure
☐ Hx of HPV Infection
☐ HX of LSIL or Higher on Pap/BX
☐ Hx of Gyn Malignancy
☐ Chemotherapy/Radiation Treatment
☐ Cryosurgery/Colpo/LEEP
☐ Other:_____

PREVOUS SMEAR(S): DATE:_____
DIAGNOSIS:_____
LAB:_____

MOLECULAR TESTING REQUEST

SOURCE (If other than Cx/Vag):_____

☐ **GONORRHEA AND CHLAMYDIA :** ☐ Vial ☐ Swab ☐ Urine

☐ **HPV** ONLY (No Pap Testing)**

☐ **VAGINITIS PANEL** (Candida, Gardnerella, Trichomonas) - Submit **BD AFFIRM™** Swab

NON-GYN CYTOLOGY REQUEST

☐ **ANAL-RECTAL CYTOLOGY**
☐ **BODY FLUID (SOURCE)** _____
☐ **NEEDLE ASPIRATION (SITE)** _____
☐ **BRUSHING / WASHING (SOURCE)** _____

☐ **SPUTUM**
☐ **URINE (*Specify Voided or Catheter collection*)** _____
☐ **OTHER**
(SOURCE)_____

TISSUE PATHOLOGY REQUEST

SPECIMEN SITE(S): **# SPECIMENS** ☐ **# CONTAINERS** ☐ ☐ SpiraBrush™

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

BREAST TISSUE; DATE & TIME PLACED IN 10% BUFFERED FORMALIN: _____/_____/_____ _____:_____

PATHOLOGY REQUISITION