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ORDERING PHYSICIAN-LAST NAME, FIRST

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

PATIENT'S STREET ADDRESS CITY, STATE, ZIP

PHONE # DATE OF BIRTH SEX M F PATIENT'S MRN S.S. NUMBER

RESPONSIBLE PARTY RELATIONSHIP TO PATIENT SUBSCRIBER'S BIRTHDAY

INSURANCE COMPANY NAME (REQUIRED) SECONDARY INSURANCE COMPANY NAME

ADDRESS ADDRESS

CITY, STATE, ZIP CODE CITY, STATE, ZIP CODE

POLICY I.D. NO. GROUP NO. POLICY I.D. NO. GROUP NO.

ADDITIONAL REPORT COPIES

TO: _____
FAX REPORT TO: _____
ATTN: _____
FAX NO. _____

COLLECTION DATE/TIME: _____ AM PM PATIENT LOCATION: _____ OFFICE _____ SAME DAY SERVICES _____ OTHER _____

GYN CYTOLOGY REQUEST

CLINICAL HISTORY: LMP ____/____/____ LAST NORMAL PAP DATE ____/____/____ LAST HPV TEST DATE ____/____/____ PREVIOUS ABNORMAL PAP/HPV ____/____/____ RESULTS OF ABNORMAL PAP/HPV _____ PREVIOUS BIOPSY DATE ____/____/____ PREVIOUS BIOPSY RESULTS _____	CHECK ALL THAT APPLY		PREVIOUS PROCEDURES/TREATMENTS CHECK ALL THAT APPLY	
	<input type="checkbox"/> ABN BLEEDING	<input type="checkbox"/> POST MENOPAUSAL	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> PARTIAL HYSTERECTOMY
	<input type="checkbox"/> ABN DISCHARGE	<input type="checkbox"/> POST PARTUM	<input type="checkbox"/> COLPOSCOPY	<input type="checkbox"/> TOTAL HYSTERECTOMY
	<input type="checkbox"/> CONTRACEPTIVE	<input type="checkbox"/> PREGNANT ____ WEEKS	<input type="checkbox"/> CONIZATION	<input type="checkbox"/> RADIATION
	<input type="checkbox"/> DES EXPOSURE	<input type="checkbox"/> PREVIOUS DYSPLASIA	<input type="checkbox"/> CRYOTHERAPY	
<input type="checkbox"/> HRT	<input type="checkbox"/> PREVIOUS UNSAT PAP	<input type="checkbox"/> LEEP		
<input type="checkbox"/> IUD	<input type="checkbox"/> VISIBLE LESION/MASS			

SPECIMEN SOURCE: _____ CERVICAL/ENDOCERVICAL _____ VAGINAL _____

An ABN (Advanced Beneficiary Notice of Noncoverage) form must be completed for ALL TRADITIONAL MEDICARE PATIENTS and sent with their specimen.

DIAGNOSTIC SECTION ONLY

INCLUDE ICD-10 (REQUIRED) PER TEST

THERE HAVE BEEN PREVIOUS ABNORMALS, SIGNS OR SYMPTOMS OF DISEASE, AT HIGHER RISK FOR STI, HAD DES EXPOSURE, OR IS IMMUNOCOMPROMISED.

THIN PREP PAP (IMAGED) _____ CHLAMYDIA _____ N. GONORRHOEAE (NG) _____
 HPV _____ MEDICARE AND COMMERCIAL INSURANCE WILL NOT COVER HPV FOR ANYONE 66 AND OLDER.

SCREENING SECTION ONLY

INCLUDE ICD-10 (REQUIRED) PER TEST

NO SIGNS OR SYMPTOMS OF DISEASE, STRICTLY PREVENTIVE IN NATURE. SCREENING THINPREP PAPS ARE IMAGED.

AGE BASED SCREENING (AGES 21-65) BASED ON ACOG, ASCCP, AND/OR USPSTF RECOMMENDED SCREENING GUIDELINES

WOMEN AGES 21-24 THINPREP PAP & CT/NG (CT/NG RECOMMENDED YEARLY): ICD-10 REQUIRED PER TEST _____
 WOMEN AGES 21-24 THINPREP PAP: ICD-10 REQUIRED _____
 WOMEN AGES 25-29 AT HIGHER RISK FOR STI: THINPREP PAP & CT/NG: ICD-10 REQUIRED PER TEST _____
 WOMEN AGES 25-29: THINPREP PAP: ICD-10 REQUIRED _____ OR PRIMARY HPV SCREENING WITH 16/18GT (PAP & HPV ICD-10s REQUIRED) _____
 ADDITIONAL TESTS: REFLEX HPV IF ASC (INCLUDES 16/18GT) REFLEX HPV IF ASC/LSIL (INCLUDES 16/18GT) REFLEX TO THINPREP PAP IF PRIMARY HPV IS POSITIVE
 FOR WOMEN AGES 30-65, CO-TESTING IS AN OPTION FOR Medicare patients if the pap has been at least 2 years and the HPV has been at least 5 years. Most Commercial Insurance will cover co-testing if the pap has been at least 3 years and the HPV has been at least 5 years. Choose an option below:
 THINPREP PAP & HPV CO-TEST WITH CT/NG (IF AT HIGHER RISK FOR STI): ICD-10 REQUIRED PER TEST _____
 THINPREP PAP & HPV CO-TEST: PAP & HPV ICD-10s REQUIRED _____
 THINPREP PAP ALONE: ICD-10 REQUIRED _____
 PRIMARY HPV SCREEN WITH 16/18 GT: PAP & HPV ICD-10s REQUIRED _____
 ADDITIONAL TESTS: REFLEX HPV IF ASC (INCLUDES 16/18GT) REFLEX HPV IF ASC/LSIL (INCLUDES 16/18GT) REFLEX TO THINPREP PAP IF PRIMARY HPV IS POSITIVE
 NOTE: WOMEN 66 & ABOVE: PAP may be performed, but Medicare and Commercial Insurance WILL NOT COVER HPV testing.

GYN ANCILLARY TESTS

INCLUDE ICD-10 (REQUIRED) PER TEST

CHLAMYDIA _____ N. GONORRHOEAE (NG) _____ HERPES SIMPLEX VIRUS 1 AND 2 mRNA _____

NON-GYN CYTOLOGY REQUEST

SURGICAL PATHOLOGY REQUEST

CLINICAL DIAGNOSIS (ICD-10 REQUIRED) _____

CLINICAL HISTORY _____ CANCER HISTORY (SITE) _____
 _____ COPD, _____ HEMATURIA, _____ HEMOPTYSIS, _____ MASS, _____ SOB, _____ PNEUMONIA

SPECIMEN SOURCE:
 _____ ANAL CYTOLOGY, _____ ANAL HPV (NOTE: ANAL HPV IS SENT TO REFERENCE LAB)
 _____ BLADDER WASH, _____ URINE (_____ CATH OR _____ VOIDED)
 _____ BRONCHIAL BRUSHING _____ R _____ L, _____ BRONCHIAL WASHING _____ R _____ L
 _____ BRONCHOALVEOLAR LAVAGE _____ R _____ L _____ COMBINED
 _____ ESOPHAGEAL/GASTRIC BRUSHING, _____ JOINT/SYNOVIAL FLUID (SITE): _____
 _____ FINE NEEDLE ASPIRATE _____ CYST, _____ SOLID MASS (SITE): _____
 _____ GMS STAIN FOR FUNGAL ORGANISMS INCLUDING PNEUMOCYSTIS
 _____ NIPPLE DISCHARGE _____ R _____ L, _____ PELVIC WASH, _____ PLEURAL FLUID
 _____ SPINAL FLUID, _____ SPUTUM

CLINICAL DIAGNOSIS (ICD-10 REQUIRED) _____

TISSUE SUBMITTED: _____

PROCEDURE: _____

SIGNATURE OF PERSON COMPLETING THIS FORM: _____