

PATIENT: \_\_\_\_\_ SS# \_\_\_\_\_

D/O/B: \_\_\_\_\_ ☐ MALE ☐ FEMALE ☐ FASTING ☐ NON FASTING

TIME & DATE COLLECTED: \_\_\_\_\_ LAST MEDICATION DATE & TIME: \_\_\_\_\_

REC. DATE / TIME \_\_\_\_\_

☐ STAT

DRAWN BY: \_\_\_\_\_

**BILLING INFORMATION: PLEASE INDICATE WHOM TO BILL**

☐ ACCOUNT ☐ PATIENT ☐ MEDICARE ☐ MEDICAID ☐ PRIVATE INSURANCE

GUARANTOR: \_\_\_\_\_ INS. CO. NAME / ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY / STATE: \_\_\_\_\_

PHONE: \_\_\_\_\_ (REQUIRED)

MEDICARE #: \_\_\_\_\_ SS# / POLICY #: \_\_\_\_\_

MEDICAID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

DX CODES: \_\_\_\_\_

**\*\*\* DIAGNOSIS CODE REQUIRED WHEN ORDERING LABORATORY TESTS \*\*\***

FAILURE TO COMPLETE BILLING INFORMATION OR DX CODES WILL RESULT IN A CHARGE TO YOUR ACCOUNT.  
PLEASE BE ADVISED MEDICARE DOES NOT PAY FOR ROUTINE SCREENING OR TESTING THEY CONSIDER MEDICALLY  
UNNECESSARY FOR THE DX CODE. PLEASE ADVISE YOUR PATIENT PRIOR TO ORDERING. THANK YOU.

**CYTOPATHOLOGY REQUEST FORM:**

**PLEASE MARK ALL TESTS TO BE PERFORMED**

<b>CONVENTIONAL PAP SMEAR:</b>	<input type="checkbox"/> SCREENING	<input type="checkbox"/> DIAGNOSTIC	<input type="checkbox"/> # OF SLIDES
<b>THIN PREP PAP SMEAR:</b> (MUST BE COLLECTED IN THIN PREP VIAL)	<input type="checkbox"/> SCREENING	<input type="checkbox"/> SCREENING WITH REFLEX TO HPV	
	<input type="checkbox"/> DIAGNOSTIC	<input type="checkbox"/> DIAGNOSTIC WITH REFLEX TO HPV	
	<input type="checkbox"/> HPV TESTING ONLY		
	<input type="checkbox"/> CHLAMYDIA TRACHOMATIS BY AMPLIFIED DNA PROBE		
	<input type="checkbox"/> NEISSERIA GONORRHOEAE BY AMPLIFIED DNA PROBE		

**SOURCE:** ☐ CERVIX ☐ ENDOCERVIX ☐ VAGINA

**CLINICAL HISTORY IS REQUIRED**

PREVIOUS PAP SMEAR RESULT AND DATE : \_\_\_\_\_

LAST MENSTRUAL PERIOD DATE : \_\_\_\_\_

<input type="checkbox"/> PREGNANT	<input type="checkbox"/> IRREGULAR MENSES	<input type="checkbox"/> PELVIC RADIATION
<input type="checkbox"/> POSTPARTUM	<input type="checkbox"/> HYSTERECTOMY	OTHER: _____
<input type="checkbox"/> BIRTH CONTROL PILLS	<input type="checkbox"/> INTRAUTERINE DEVICE	
<input type="checkbox"/> ESTROGEN THERAPY	<input type="checkbox"/> VAGINAL IRRITATION	

ABSENCE OF CLINICAL HISTORY CAN LIMIT EVALUATION OF THE SPECIMEN

THE PAP SMEAR IS A SCREENING TEST FOR CERVICAL CANCER WITH AN INHERENT FALSE NEGATIVE RATE.  
THE PAP SMEAR SHOULD NOT BE THE SOLE CRITERIA FOR DETERMINING THE PRESENCE OR ABSENCE OF  
CERVICAL CANCER.