



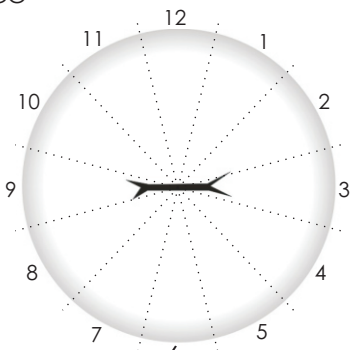
Specimen Collection Date: _____ Time: _____

PATIENT INFORMATION			
Patient Name (Last, First, MI)			Chart#
SSN	DOB	Sex M / F	
Address			
City	State	ZIP	Phone

PHYSICIAN INFORMATION

Patient Insurance Information - Please provide copy of insurance card(s)			
Primary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Ins. <input type="checkbox"/> Patient <input type="checkbox"/> Client Bill			
<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	
Company			
Policy / ID Number			
Group Number			
Secondary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Ins.			
<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	
Company			
Policy / ID Number			
Group Number			

GYNECOLOGIC HISTOLOGY (DIAGRAM)
<input type="checkbox"/> A. Endocervical Curretting -ECC <input type="checkbox"/> B. Endometrial Biopsy - EMB <input type="checkbox"/> C. Cervical Biopsy <input type="checkbox"/> D. Cervical Cone <input type="checkbox"/> E. Labial Biopsy <input type="checkbox"/> F. LEEP - Anterior <input type="checkbox"/> G. LEEP - Posterior <input type="checkbox"/> H. Perineum Biopsy <input type="checkbox"/> I. Vaginal Biopsy <input type="checkbox"/> J. Vulvar Biopsy <input type="checkbox"/> K. Colposcopy <input type="checkbox"/> Other _____



DIAGNOSTIC INFORMATION (ICD-9) Check all that apply
<input type="checkbox"/> V15.89 Other Specified Personal History presenting hazard to health
<input type="checkbox"/> V22.2 Pregnancy
<input type="checkbox"/> V76.2 Routine Cervical Pap Smear
<input type="checkbox"/> V76.47 Screen for Malignant neoplasm, vagina
<input type="checkbox"/> 180.9 Malignant Neoplasm Cervix
<input type="checkbox"/> 616.0 Cervicitis
<input type="checkbox"/> 616.10 Vaginitis
<input type="checkbox"/> 622.10 Dysplasia Cervix
<input type="checkbox"/> 626.8 Abnormal Bleeding
<input type="checkbox"/> 627.1 Postmenopausal Bleeding
<input type="checkbox"/> 627.3 Atrophic Vaginitis
<input type="checkbox"/> 795.00 Abnormal Cervical Pap Smear
<input type="checkbox"/> 795.08 Previously Unsatis. Pap Smear
<input type="checkbox"/> OTHER

GYN CYTOLOGY
SPECIMEN SOURCE <input type="checkbox"/> Cervix/Endocervix <input type="checkbox"/> Vagina <input type="checkbox"/> Breast TEST SUBMITTED <input type="checkbox"/> Pap Test - Liquid Based <input type="checkbox"/> Thin Prep™ <input type="checkbox"/> SurePath™ <input type="checkbox"/> DNA Pap (High Risk HPV & Pap)*recommended in women>30Yrs ThinPrep™ or SurePath™ <input type="checkbox"/> Medicare Screening Pap Smear (Must check 1 below) <input type="checkbox"/> Low Risk, Cervical - Every 2 yrs Dx: V76.2 Routine Cervical Pap Smear <input type="checkbox"/> Low Risk, Vagina - Every 2 yrs Dx: V76.49 screen for malignant neoplasm, vagina <input type="checkbox"/> Low Risk, Routine gynecological examination - Every 2 yrs Dx: V72.31 Routine gynecological examination(Eff. July 1, 2005) <input type="checkbox"/> High Risk - Medical History - 1 per year Dx: V15.89 Other specified personal history presenting hazards to health Medicare patients with screening Paps must sign the ABN located on the back <input type="checkbox"/> HALO™ Breast Pap Test DATE LMP ___ / ___ / ___ month Day Year

CLINICAL INFORMATION (Check all that apply)
<input type="checkbox"/> Abnl. Appearing Cervix <input type="checkbox"/> BC / OCP <input type="checkbox"/> Postpartum <input type="checkbox"/> Depo Provera <input type="checkbox"/> History of Adeno Ca <input type="checkbox"/> IUD <input type="checkbox"/> History Invasive CA <input type="checkbox"/> Pregnant <input type="checkbox"/> Prior Conization <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Colposcopy w/ Biopsy <input type="checkbox"/> Prior Hysterectomy <input type="checkbox"/> Prior Cryosurgery <input type="checkbox"/> Post Menopausal <input type="checkbox"/> Prior LEEP/Laser Surgery <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> History of Radiation <input type="checkbox"/> History of Abnormal Pap - Specify _____ <input type="checkbox"/> Other _____

MOLECULAR
<input type="checkbox"/> HPV (High Risk)Reflex if ASC-US <input type="checkbox"/> HPV (High Risk) Only (No Pap) <input type="checkbox"/> HPV Type 16 & 18 - Reflex if High Risk Positive <input type="checkbox"/> Gonorrhea / Chlamydia <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Herpes 1 & 2 <input type="checkbox"/> Vaginosis Panel (<i>Trichomonas, Candida, Gardnerella</i>) <input type="checkbox"/> Cystic Fibrosis Panel <input type="checkbox"/> Other _____

PHYSICIAN INSTRUCTIONS

1. Complete the requisition with all requested information.
2. Clearly print the patient name on the label (do not write on the bar code)
3. Place one label on each specimen container(not the lid)
4. Medicare patients with a screening Pap smear must sign the ABN located on the back of this requisition.

ThinPrep™ Pap SurePath™ Pap GYN000000 Name: _____	Cervical Cone GYN000000 Name: _____	Anterior Loop GYN000000 Name: _____	HALO Breast Pap Test - L GYN000000 Name: _____
HPV Only GYN000000 Name: _____	Cervical Biopsy GYN000000 Name: _____	Posterior Loop GYN000000 Name: _____	HALO Breast Pap Test - R GYN000000 Name: _____
Group B Strep GYN000000 Name: _____	Colpo Biopsy GYN000000 Name: _____	Perineum GYN000000 Name: _____	O'Clock Cervical Biopsy GYN000000 Name: _____
Vaginosis Panel GYN000000 Name: _____	ECC GYN000000 Name: _____	Vaginal Biopsy GYN000000 Name: _____	O'Clock Cervical Biopsy GYN000000 Name: _____
Herpes 1 & 2 GYN000000 Name: _____	EMB GYN000000 Name: _____	Vulvar Biopsy GYN000000 Name: _____	 GYN000000 Name: _____