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Additional copies to _____

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Address _____

PATIENT INFORMATION		PLEASE PRINT	
Last name,		First name	
Street Address			
City		State	Zip
Patient's Phone # () - -	Circle One M F	Age	Birth Date
Social Security #		Date Collected	

BILL TO:		PLEASE ATTACH COPY OF PATIENT'S INSURANCE CARD	
Carrier Name		Medical Group Name	
Address			
City		State	Zip
Insured's ID / Policy #		Insured's Group #	
Insured's Name		Relationship to Insured Self / Spouse / Child	

REASON FOR TESTING (Please check all that apply)	
Screening (no signs or symptoms of disease) <input type="checkbox"/> Routine screening Pap, cervical <input type="checkbox"/> Routine screening Pap, vaginal <input type="checkbox"/> Routine vaginal Pap. history of neoplasm, other site <input type="checkbox"/> Screening Pap for high-risk patients <input type="checkbox"/> Screening for HPV <input type="checkbox"/> Screening for venereal disease CT/GC <input type="checkbox"/> Other _____	Diagnostic (signs, symptoms or history of disease) <input type="checkbox"/> Atypical glandular cells, endocerv/endomet <input type="checkbox"/> ASCUS on Pap <input type="checkbox"/> ASC-H on Pap <input type="checkbox"/> LGSIL on Pap <input type="checkbox"/> HGSIL on Pap <input type="checkbox"/> HR HPV test positive <input type="checkbox"/> CIN I, mild dysplasia <input type="checkbox"/> CIN II, moderate dysplasia <input type="checkbox"/> CIN III, severe dysplasia <input type="checkbox"/> Malignant neoplasm, cervix <input type="checkbox"/> Cervicitis <input type="checkbox"/> Vaginitis <input type="checkbox"/> Postmenopausal Bleeding <input type="checkbox"/> Dys. uterine bleeding <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Unsatisfactory smear <input type="checkbox"/> Unspec. inflam. disease <input type="checkbox"/> Other: _____

NON-GYN CYTOLOGY REQUEST
<input type="checkbox"/> Breast cyst <input type="checkbox"/> Urine cytology <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Fine Needle Aspiration (FNA) Site: _____ <input type="checkbox"/> Other _____ # of fixed slides: _____ # of air-dried slides _____

BIOPSY REQUEST
BIOPSY SITE(S) # SPECIMENS _____ # CONTAINERS _____ <input type="checkbox"/> CORRELATE BIOPSY WITH PRIOR PAP SMEAR IF DISCREPANT

GYN CYTOLOGY REQUEST
<input type="checkbox"/> Pap Test as indicated by guidelines (See back of requisition) <input type="checkbox"/> Pap Test with HPV* cotest <input type="checkbox"/> Pap Test w/reflex HPV* if ASC <input type="checkbox"/> Pap Test <input type="checkbox"/> HPV* Test <input type="checkbox"/> N. gonorrhea & chlamydia <input type="checkbox"/> *Reflex to 16/18/45 genotyping when HPV pos.

FOR LAB USE
Procedure: _____
Clinical history / Diagnosis: _____

SOURCE/COLLECTION METHOD
<input type="checkbox"/> Cervix/endocervix <input type="checkbox"/> Vaginal <input type="checkbox"/> ThinPrep <input type="checkbox"/> Swab

LMP ____ / ____ / ____ LAST PAP DATE ____ / ____ / ____
 Accession No. _____ Lab _____

PLEASE PLACE A LABEL ON THE SPECIMEN BAG & CONTAINER(S)