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PSP USE ONLY:

Surgical Pathology/Gyn-Cytology Request Form

PATIENT INFORMATION

Last First M

SSN

Date of Birth Sex (circle one) M F

Address

City, State ZIP

Phone

Label specimens with patient info and tissue type submitted and place in bio-bag

PHYSICIAN INFORMATION

Date

Office site

Ordering physician

Copies to

Physician Signature

☐ **Bill Insurance** Please attach photocopy of patient's Insurance card ☐ **Self pay** ☐ **Client bill**

PATHOLOGY SPECIMEN

1.
2.
3.
4.
5.
6.

CLINICALHX/ICD-10

1.
2.
3.
4.
5.
6.

GYN CYTOLOGY

Previous Pap Smear (Date and Diagnosis if not PSP)

☐ Screening (Z12.4)
☐ High Risk Screening (Z92.89)
☐ Diagnostic

If Medicare, submit ABN if applicable

ICD-10 _____

Source **LMP:** _____

☐ Cervical ☐ Thin Prep ☐ Swab
☐ Vaginal ☐ Sure Path ☐ Other

Additional Tests (check all that apply)

☐ HPV/Reflex ASC-US
☐ HPV-Co-Testing (30-65 years)
☐ HPV– any interpretation
☐ HPV Type 16/18 (if HR HPV + ve)
☐ Other _____

☐ C. Trachomatis
☐ N. Gonorrhea
☐ Gp B Strep
☐ Herpes Simplex Types I & II
☐ Vaginosis panel Candida, Trichomonas, Gardnerella

Check All That Apply

☐ Chemo/Rad Rx
☐ Exposure to VD
☐ High risk sex behav
☐ Hormone Rx
☐ HR HPV (Hx of)
☐ Hysterectomy
☐ Irreg. menses
☐ IUD
☐ LEEP/cone bx
☐ OCP
☐ Post coital bleed
☐ Post menopausal
☐ Cancer, type _____
☐ Other _____
☐ Post meno bleed
☐ Post partum
☐ Pregnant

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