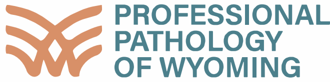

111 S. Jefferson St., Suite 150
B Casper, WY 82601
Phone: 307-337-1670
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GYN & Non-GYN Cytology Specimen Requisition

_____-_____-_________ Patient's Social Security #

_____/_____/_______ Date of Birth:

Collection Date: _____/_____/_______

Submitting Physician:

Name / Practice ____________________

Street Address ____________________

City ____________________ State ______

Zip ______ Phone _____-_____-_______

Fax _____-_____-_______

Bill To: ☐ Self-Pay *(Patient)* ☐ Face Sheet Attached

☐Medicare# ____________________

☐Medicaid# ____________________

Patient Last Name / First Name / Middle Name ____________________

Street Address ____________________

City ____________________ State ______ Zip ______

Male ☐ Female ☐ Gender

Patient Phone #: _____-_____-_______

Guarantor Last / First Name: *(If different from Patient)* ____________________

Street Address *(If different from Patient)* ____________________

City ____________________ State ______ Zip ______

☐ Self ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: ________
Guarantor Relationship to Patient

ICD Codes

☐Z01.411 – Annual Gyn, with findings ☐ Z01.419 – Annual Gyn, without findings

☐ Other: ____________ ☐ Z33.1-Pregnancy ☐ N93.8-Abnormal Bleeding ☐ N95.0-PMB

☐ R87.619-Abnormal Pap, Other ☐ R87.610-ASCUS ☐ R87.612-LSIL ☐ R87.613-HSIL

Cytopathology (Gynecological)

Source: ☐ Cervical/Endocervical ☐ Endocervical Only ☐ Vaginal ☐ Other:____________

☐ **Screening Pap:** ***This Pap smear is part of the routine physical exam. (No Patient Complaints)***

☐ **Diagnostic Pap:** ***Previous abnormal tests, findings, symptoms, or significant complaints.***

☐ **HPV HR - ASCUS Only**[1] ☐ **HPV HR**[1] ☐ **CT/NG**

☐ **Trichomonas**

History: LMP:__________ **Date Last PAP:**__________

☐ Weeks Pregnant:_____ ☐ Weeks Postpartum:_____ ☐ Weeks Pregnant:_____

☐ IUD in place ☐ Hormonal Therapy ☐ Abnormal Cervix

☐ Gynecological complaint ☐ Previous gyn. surgery ☐ Previous gyn. cancer

☐ Chemotherapy / Radiation ☐ Previous abnormal Pap ☐ Significant non-gyn. disease / abnormalities

[1] By ordering this test, the clinician acknowledges that additional reflex HPV HR 16, 18/45 testing will be performed and billed at a separate additional charge.

Cytopathology (Non-Gynecological)

Specimen Type:

☐ Esophageal Brushing ☐ Bronchial Washing

☐ Urine *(Voided)* ☐ Urine *(Catheterized)*

☐ Urine *(Other)*:__________ ☐ Gastric Brushing

☐ Bronchial Brushing ☐ Peritoneal Effusion

☐ Bronchial Lavage ☐ Pleural Fluid

☐ Sputum ☐ Bladder Washing

☐ FNA (Specify):____________________

☐ Other (Specify):____________________

Relevant History:

☐ = A Required Response