PHYSICIAN:

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Patient's Last Name	First	M.I.	SSN

Sex: M F	DOB:	Age	Date Collected	MRN	Relationship to Insured/Responsible Party: ____Self ____Spouse ____Dependent

Address of Patient (or of Insured/Responsible Party if not the Patient)	Patient Phone #

City	State	Zip	Name of Insured/Responsible Party if not the Patient

Insurance Category:
- ☐ Medicare
- ☐ Medi-Cal
- ☐ Self-Pay (bill patient)
- ☐ Private Pay/PPO
- Other:______________________

Insurance Information (please attach copy of insurance card, front & back):
Insurance Co. Name: ____
Member/Insured ID #: ______________________________ Group #: ______________________________
Insurance Address: ____
City: ______________________________ State: ____________ Zip: ____________________
MediCare #: ______________________________ Suffix: ____________________
Medi-Cal #: ______________________________

ICD DIAGNOSIS CODE: REQUIRED

Pap Smear – Medicare/Medi-Cal – Please check ONE:
- ☐ Screening Pap: **routine** (reimbursable once every 2 yrs.)
- ☐ Screening Pap: **high risk** factor: ___________________
- ☐ Diagnostic Pap: **history** of abnormality or signs of symptoms of medical necessity (ICD code to left)
- ☐ Pap Smear: **non-covered** services (attach signed ABN)

NOTE: All slides must be labeled *in pencil* with patient's full name. All specimen containers must be labeled with patient's full name *and* the source of the specimen it contains. The lab will reject all unlabeled slides/specimens.

GYN Cytology

ThinPrep® and Aptima HPV® mRNA
- ☐ Pap w/ age-based screening protocols for Cervical Cancer and CT/GC (*Based on ACOG and CDC guidelines*)
- ☐ Pap + HPV + Reflex 16, 18/45 Genotyping (Recommended for women 30+)
- ☐ Pap + HPV
- ☐ Pap + Reflex HPV if ASC-US (Recommended for women 21-29)
- ☐ ThinPrep Pap **Only**

*All paps include image-guided screening

Out of the Vial Testing
- ☐ CT/NG (Both)
- ☐ Chlamydia trachomatis (CT)
- ☐ Neisseria gonorrhoeae (NG)
- ☐ Trichomonas vaginalis
- ☐ Aptima HPV mRNA
- ☐ Aptima HPV mRNA, reflex genotyping 16, 18/45

Source:
- ☐ Cervical/Endocervical
- ☐ Vaginal
- ☐ Other: ______________________

LMP: _______ /_______ /_________

Prev ACC #: ______________________

Date: _______ /_______ /_________
Diagnosis:
____

Check all that apply:
- ☐ Pregnant
- ☐ Post-Partum
- ☐ Post-Menopausal
- ☐ Abnormal Bleeding
- ☐ Total Hysterectomy
- ☐ Partial Hysterectomy
- ☐ BCP
- ☐ Hormones
- ☐ IUD
- ☐ Leep/Cone
- ☐ Chemo/Rad

Non-GYN Cytology

LT	RT		LT	RT	
☐	☐	☐ Thyroid FNA ☐ Cystic ☐ Solid	☐	☐	☐ L. Node FNA Site: ______________
☐	☐	☐ Breast FNA	☐	☐	☐ Pleural Fluid
☐	☐	☐ Breast Halo	☐	☐	☐ Bronchial Washing
☐	☐	☐ Nipple Discharge	☐	☐	☐ Bronchial Brushing

☐ Sputum ☐ Expectr ☐ Induced | ☐ Peritoneal Fluid

Molecular Testing (Aptima)

	Swab	Urine
Vaginitis Panel for **Symptomatic** Patients *(CT/NG, Trichomonas Vag.)*	☐	☐
Chlamydia + Gonorrhea **(Both)**	☐	☐
Chlamydia **Only**	☐	☐
Gonorrhea **Only**	☐	☐
Trichomonas **Only**	☐	☐

☐ CSF | ☐ Urine | Other, source/method: ____

Surgical Biopsy/Tissue: Biopsy Site(s) – Please list: (please specify the site of each biopsy)

1)	2)	3)
4)	5)	6)

Clinical Diagnosis, Pertinent History and Operative Findings and Additional Requests: ______________________________
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