



PHYSICIAN:

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Patient's Last Name		First	M.I.	SSN
Sex: M F	DOB:	Age	Date Collected	MRN
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: <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Self-Pay (bill patient) <input type="checkbox"/> 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 #: _____
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ICD DIAGNOSIS CODE: REQUIRED <table border="1"> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>									Pap Smear – Medicare/Medi-Cal – Please check ONE: <input type="checkbox"/> Screening Pap: routine (reimbursable once every 2 yrs.) <input type="checkbox"/> Screening Pap: high risk factor: _____ <input type="checkbox"/> Diagnostic Pap: history of abnormality or signs of symptoms of medical necessity (ICD code to left) <input type="checkbox"/> 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 <input type="checkbox"/> Pap w/ age-based screening protocols for Cervical Cancer and CT/GC (Based on ACOG and CDC guidelines) <input type="checkbox"/> Pap + HPV + Reflex 16, 18/45 Genotyping (Recommended for women 30+) <input type="checkbox"/> Pap + HPV <input type="checkbox"/> Pap + Reflex HPV if ASC-US (Recommended for women 21-29) <input type="checkbox"/> ThinPrep Pap Only *All paps include image-guided screening	Out of the Vial Testing <input type="checkbox"/> CT/NG (Both) <input type="checkbox"/> Chlamydia trachomatis (CT) <input type="checkbox"/> Neisseria gonorrhoeae (NG) <input type="checkbox"/> Trichomonas vaginalis <input type="checkbox"/> Aptima HPV mRNA <input type="checkbox"/> Aptima HPV mRNA, reflex genotyping 16, 18/45	Source: <input type="checkbox"/> Cervical/Endocervical <input type="checkbox"/> Vaginal <input type="checkbox"/> Other: _____ LMP: ____ / ____ / ____ Prev ACC #: _____ Date: ____ / ____ / ____ Diagnosis: _____	Check all that apply: <input type="checkbox"/> Pregnant <input type="checkbox"/> Post-Partum <input type="checkbox"/> Post-Menopausal <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Total Hysterectomy <input type="checkbox"/> Partial Hysterectomy <input type="checkbox"/> BCP <input type="checkbox"/> Hormones <input type="checkbox"/> IUD <input type="checkbox"/> Leep/Cone <input type="checkbox"/> Chemo/Rad
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Non-GYN Cytology				Molecular Testing (Aptima)			
LT	RT			LT	RT	Swab	Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thyroid FNA	<input type="checkbox"/> Cystic Solid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Breast FNA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Breast Halo		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nipple Discharge		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sputum	<input type="checkbox"/> Expectr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Induced		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CSF	<input type="checkbox"/> Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, source/method: _____				Vaginitis Panel for Symptomatic Patients (CT/NG, Trichomonas Vag.) Chlamydia + Gonorrhea (Both) Chlamydia Only Gonorrhea Only Trichomonas Only			

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: _____