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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. _______

CLINICAL HX/ICD-9

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

GYN CYTOLOGY

Previous Pap Smear (Date and Diagnosis if not PSP)

- ☐ Screening (V76.2)
- ☐ High Risk Screening
- ☐ Diagnostic

If Medicare, submit ABN if applicable
ICD-9 _______

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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