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CYTOPATHOLOGY REQUISITION

Patient Information - PLEASE PRINT or use label	***Billing Information:***
Medical Record #	****Please list or attach the following insurance***
Patient SS# (optional)	Ins. Company Name
Patient Name	Ins. Co. Address
Birthdate **Sex**: ☐Male ☐Female	City/State/Zip
Patient Address	Policy # Group #
City/State/Zip	Patient Relationship to Insured: ☐Self ☐Spouse ☐Child
Phone # (H) (W)	Insured's Name
Physician	*Does patient have other insurance?* ☐*No* ☐*Yes-Send Info*
Copy To	
Order Date/Initials Account Code	

GYN Specimen

Sample Date: _____

SPECIMEN SOURCE: *(Select One)*
- ☐ Cervical/Endocervical Combined
- ☐ Vaginal Only
- ☐ Endocervical Only
- ☐ Vulvar Lesion
- ☐ Other _____

TESTS: *(Select One)*
- ☐ Liquid based pap test **with reflex high risk HPV for ASCUS**
- ☐ Liquid based pap test **with reflex high risk HPV testing for ASCUS OR SIL**
- ☐ Liquid based pap test AND high risk HPV test ("Cotest")
- ☐ Liquid based pap test **only**
- ☐ High risk HPV screen **only** – Referred to Mayo

Clinical Information and History:

LMP Date_____ ☐ Postmenopausal **Previous Abnormal Pap Date:** _____

- ☐ Pregnant Currently
- ☐ Postpartum
- ☐ Abnormal Bleeding
- ☐ Hysterectomy ☐Check if Supracervical
- ☐ IUD Present
- ☐ Cryosurgery
- ☐ LEEP
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ DES Exposure
- ☐ Oral Contraceptives
- ☐ Hormone Replacement

Other: _____

Screening:
ICD10: _____

Diagnostic:
ICD10: _____

If Medicare, did patient sign an ABN? ☐No ☐Yes

NON-GYN Specimen

Date of Sample: _____ **ICD10 Code(s):** _____

SOURCE:
- ☐ Urine, voided
- ☐ Urine, Instrumented
- ☐ Sputum
- ☐ Fluid _____
- ☐ FNA _____
- ☐ Other _____

CLINICAL HISTORY:

_____

_____