



PATIENT INFORMATION	Last	First	M
	SSN		
	Date of birth	Sex (circle one) M F	
	Address		
	City, State ZIP		
	Phone		

PHYSICIAN INFORMATION	Date
	Office site
	Ordering physician
	Primary care / Copies to
	PRECERT / PREAUTHORIZATION / REFERRAL #

Insurance	Primary Insurance Name:	Secondary Insurance Name:
	Insurance Address:	Insurance Address:
	Certificate or ID #:	Certificate or ID #:
	Group #:	Group #:
	Subscriber Name: Relationship:	Subscriber Name: Relationship:

CLINICAL HISTORY / MEDICATIONS / ICD-9 or DIAGNOSIS

SURGICAL AND NON-GYN CYTOLOGY	Tissues or Non-GYN Cytology Submitted
	a.
	b.
	c.
	d.
	e.
	f.
	g.
h.	

GYN-CYTOLOGY	Required	If Medicare, follow policy. Submit Advance Beneficiary Notice (ABN), if ap-
	<input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic	
	ThinPrep Source	
	<input type="checkbox"/> Cervical <input type="checkbox"/> Vaginal LMP:	
	Additional Tests	
<input type="checkbox"/> HPV - High-Risk <input type="checkbox"/> CT/GC on ThinPrep <input type="checkbox"/> HPV - High-Risk if ASCUS		
Check All That Apply		
<input type="checkbox"/> Cancer <input type="checkbox"/> IUD <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Pregnant <input type="checkbox"/> Hormonal Rx <input type="checkbox"/> Cryo Rx <input type="checkbox"/> Other <input type="checkbox"/> Oral Contr. <input type="checkbox"/> LEEP		