



Surgical and GYN Cytology Request

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
	Copies to
	Precertification / Preauthorization / Referral #
	Special Instructions

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE CARD

Slides for DPS Consultation (and Testing Deemed Essential)

Specimens for Diagnosis with Essential Testing

SURGICALS	A.
	B.
	C.
	D.
	E.
	F.
	G.
	H.
	I.

<input type="checkbox"/> Screening Pap	<input type="checkbox"/> Diagnostic Pap	<input type="checkbox"/> ThinPrep
<input type="checkbox"/> Screening for Microorganisms (no Pap)		<input type="checkbox"/> SurePath
Source		
<input type="checkbox"/> Oral	<input type="checkbox"/> Anal	If Medicare: Submit Advance Beneficiary Notice (ABN)
<input type="checkbox"/> Cervical	<input type="checkbox"/> Vaginal	
Additional Tests		
<input type="checkbox"/> STI Panel - HPV, CT, GC, HSV, BV	<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/> HPV - High, Low & Other	<input type="checkbox"/> CT/GC	
<input type="checkbox"/> HPV - Reflex (H, L & O)	<input type="checkbox"/> GBS	
<input type="checkbox"/> BV - Gardnerella, Trichomonas, Candida	<input type="checkbox"/> HSV	
Urine		
<input type="checkbox"/> CT	<input type="checkbox"/> Trich	<input type="checkbox"/> Culture
<input type="checkbox"/> GC	<input type="checkbox"/> Cytology	
Check All That Apply		
<input type="checkbox"/> Cancer	<input type="checkbox"/> IUD	<input type="checkbox"/> Total Abdominal Hysterectomy (TAH)
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Hormonal Rx	
<input type="checkbox"/> Other	<input type="checkbox"/> Cryo Rx	<input type="checkbox"/> Supracervical Hysterectomy
<input type="checkbox"/> LEEP	<input type="checkbox"/> Oral Contraceptive	

Label specimens with patient information and tissue type submitted and place in a biohazard bag

CLINICAL HISTORY / MEDICATIONS / ICD-9 or DIAGNOSIS	
Previous Pap Smear Date: ____/____/____	Diagnosis if not DPS: _____
LMP: ____/____/____	