CYTOPATHOLOGY REQUISITION

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FOR OFFICE USE ONLY

Patient________________________________ DOB____/____/_____ AGE_____ Sex___ SSN____________________ Date____________

Patient Phone #______________Patient Address________________________________ City ______________State __________Zip_______

Primary Insurance______________________________ Policy #__________________________ Group #______________________________

Subscriber______________________________ Relation to Patient____

Secondary Insurance___________________________ Policy #__________________________ Group#______________________________

Subscriber______________________________ Relation to Patient____

☐ Cash Pay – Family Medicine Residency of Idaho ☐ Women's Health Check (WHC)

GYN SOURCE: ☐ Cervical/Endocervical ☐ Vaginal **NON-GYN SOURCE SITE:** _____________________

☐ Thin Prep Pap Smear ☐ Conventional Pap Smear

LMP Date: _______/_______/_______

PAP/HPV/Oncogene Testing (select ONE):

- ☐ Pap only (No ancillary testing)
- ☐ High-risk HPV only (No Pap)
- ☐ Pap + reflex HPV if ASCUS (ages 21-29)
- ☐ Pap & HPV (co-testing for ages 30-65)
- ☐ Pap & HPV Co-testing with reflex genotyping 16, 18/45 if negative pap, positive HPV and age 30-65 (do not order if under age 30).

Menstrual History: **Treatment History:** **Malignancy History:**

Clinical History:

Menstrual History	Treatment History	Malignancy History	Clinical History
☐ Pregnant	☐ Radiation	☐ Cervical	☐ Wellness Exam
☐ Postpartum	☐ Chemotherapy	☐ Endometrial	☐ Previous Atypia
☐ Premenopausal	☐ Estrogen RX	☐ Uterine	☐ Other_____________________
☐ Postmenopausal	☐ OCP	☐ Ovarian	
☐ Post Hysterectomy	☐ Ablation	☐ Vulvar	
☐ Supracervical Hysterectomy	☐ IUD	☐ Vagina	
☐ Other _________________	☐ Cervical Cone/LEEP	☐ Other_______________	
	☐ Cryotherapy		
	☐ Other ________________		

For Medicare: ☐ Screening Pap? attach ABN ☐ Diagnostic Pap? use ICD9 code _______________

SUBSPECIALTY/PATHOLOGIST REQUEST

☐ Cytopathologist
☐ Attention Dr. ____________________________

PHYSICIAN ______________________________

ADDRESS ______________________________

PHONE ______________________________

FAX ______________________________

☐ **PHONE REPORT**
☐ **FAX REPORT**

Copies To: ______________________________

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MD Signature ______________________________

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