☐ RUSH

PML PATHOLOGY

Cytology Requisition

10 Medical Park Drive
Asheville, NC 28803
Ph. (828) 253-0762
Fax. (828 254-4892
www.pmlpathology.com

PATIENT INFORMATION

DATE OF EXAM	CHART #	PHYSICIAN	
NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)			DATE OF BIRTH MM/DD/YYYY
ADDRESS		CITY	STATE ZIP
SEX M ☐ F ☐	PHONE	SOCIAL SECURITY #	

INSURANCE

INSURED'S NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)

INSURANCE PLAN/PROGRAM NAME	POLICY #	GROUP #/EMPLOYER

RELATIONSHIP TO PATIENT

☐ Self ☐ Spouse ☐ Child ☐ Other

Guidelines

In accordance with current cervical cancer screening guidelines and best practices, additional testing should be done in the following cases:

CRITERIA:	TEST:
Women age 24 and over with any ASC-US result	High Risk HPV
Women age 30 - 64 with positive HPV and negative Pap	HPV Genotyping for 16 / 18 / 45

An ABN form is required for Medicare patients receiving a routine Pap at an interval of less than 2 years.

Special Requests:

Gynecologic Specimen Information for Pap

PAP SOURCE	PAP CATEGORY	DATE OF LMP
☐ Cervical	☐ Screening	
☐ Endocervical	☐ Diagnostic/Repeat	
☐ Vaginal Cuff	☐ High Risk	
	☐ No Pap - Molecular only	

Patient History - Check all that apply

☐ Pregnant	☐ Post Partum	☐ BCP
☐ Nursing	☐ Menopausal	☐ DEPO
☐ Vaginal Discharge	☐ Postmenopausal	☐ IUD
☐ Hx of STD	☐ Abnormal Bleeding	☐ Estrogen Rx
☐ Hysterectomy	☐ Prior Carcinoma	☐ HRT
☐ High Risk Sexual Behavior	☐ Radiation Treatment	☐ No Hormones
		☐ Other_______

Gynecologic and HPV Testing

☐ Pap only - no HPV	☐ HPV only - previous ASC-US
☐ Pap with reflex HPV (regardless of age)	☐ HPV only - screening
☐ Pap + HPV (co-testing)	☐ Reflex to genotyping if + HPV

STI Testing

☐ Swab ☐ ThinPrep Vial ☐ Urine

☐ Chlamydia / Gonorrhea ☐ Trichomonas ☐ HSV ☐ _______________

Dx Code _______________

Tissue

☐ SURGICAL TISSUE / SPECIMEN SUBMITTED

	SPECIMEN SOURCE / SITE	CLINICAL HISTORY
A.		
B.		
C.		

Non-Gyn Cytology

SPECIMEN SOURCE/CLINICAL HX _______________

☐ Fine Needle Aspiration			☐ Anal/Rectal	☐ Fluid, Ascites	☐ Respiratory, BAL
☐ Breast	Right	Left	☐ Gout Crystals	☐ Fluid, Pleural	☐ Respiratory, Brushing
☐ Lymph Node	Right	Left	☐ Herpes Smear	☐ Pelvic Washing	☐ Respiratory, Washing
☐ Neck	Right	Left	☐ Nipple Discharge Right Left	☐ Urine, Voided	☐ Respiratory, Sputum
☐ Parotid Gland	Right	Left	☐ Fluid, Bladder Washing	☐ Urine, Catheterized	☐ Other _______
☐ Thyroid	Right	Left	☐ Fluid, Barbotage	☐ Vulvar	
☐ Other_______					

LAB

☐ Satisfactory ☐ Negative for Intraepithelial Lesion or Malignancy

☐ Unsatisfactory ☐ *Epithelial Cell Abnormality*

CT _______________

Date _______________