LMC PATHOLOGY SERVICES
An Aytu Diagnostics Partner

WOMEN'S DX
Women's Pathology Services

LABEL HERE

GYNECOLOGICAL CYTOLOGY REQUISITION

CLIENT INFORMATION

Send duplicate report to	Name:	Fax:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	PATIENT ID NUMBER

ADDRESS	☐ MALE ☐ FEMALE	DATE OF BIRTH / /
CITY / STATE / ZIP	PHONE ( )	

BILLING INFORMATION

PLEASE ATTACH A COPY OF THE PATIENT'S DRIVERS LICENSE - FRONT AND BACK - AND A COPY OF THE PATIENT'S INSURANCE CARD - FRONT AND BACK

Financial and release of information authorization: In consideration for services rendered, I/we hereby assign the benefits due me covering the services provided by Laboratory Medicine Consultants, including major medical benefits. I/we authorize the release of information necessary for insurance purposes. Furthermore, that in consideration of service rendered to the patient, I/we hereby obligate myself/ourselves to assume responsibility for full payment of account.

NAME OF INSURED (SUBSCRIBER)	LAST	FIRST	MI

PATIENT IS: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE	ID NUMBER	GROUP NAME/NUMBER

INSURANCE ADDRESS ☐ PPO ☐ HMO	CITY	STATE/ZIP

SECONDARY INSURANCE/ADDRESS ☐ PPO ☐ HMO	ID NUMBER	GROUP NAME/NUMBER

INSURED PATIENT SIGNATURE FOR FINANCIAL AND RELEASE OF INFORMATION	DATE	PLEASE BILL (CHECK BOX)
		☐ DOCTOR/CLIENT ☐ PATIENT ☐ INSURANCE

IMPORTANT MEDICARE PATIENTS: THE ADVANCE BENEFICIARY NOTICE, IF REQUIRED, MUST BE COMPLETED, SIGNED BY THE PATIENT, AND ATTACHED **IMPORTANT**

ICD 9 CODE ☐ Routine Cervical Pap (V76.2) ☐ Routine GYN examination (V72.31) ☐ Post Hyst. Vag. Pap (V 76.47) ☐ Other Sites/Noncervical (V76.49) (Required) ☐ High-Risk Patient Pap (V15.89) ☐ Special Screening Examination for Unspecified Chlamydial Disease (V73.98) ☐ Special Screening Examination for Human Papillomavirus (HPV) (V73.81) ☐ Other Special Screening Breast Examination (V76.19) ☐ Special Screening Examination for Venereal Disease; Screening for bacterial and spirochetal sexually transmitted diseases. Screening for sexually transmitted diseases NOS (V74.5) ☐ Diagnostic _____

DIAGNOSIS (SPECIFY ICD 9)	1.	2.	3.	4.

SPECIMEN INFORMATION: COLLECTION DATE ____/____/____ COLLECTION TIME ____:____ AM PM

CLINICAL INFORMATION

Last Menstrual Period:
____/____/____

Last Pap Date: _____

Diagnosis: _____

Clinical History

- ☐ Routine Examination
- ☐ Prior Abnormal Pap
- ☐ Abnormal Vaginal bleeding
- ☐ Birth Control Pills
- ☐ Chemotherapy/Radiation
- ☐ Cigarette Smoker
- ☐ Depo-Provera®
- ☐ Estrogen replacement therapy
- ☐ Herpes
- ☐ History of HPV or dysplasia
- ☐ Immunosuppressed
- ☐ IUD
- ☐ Menopausal
- ☐ Postpartum (weeks)
- ☐ Pregnant (weeks)
- ☐ Previous GYN malignancy
- ☐ Supracervical hysterectomy
- ☐ Total hysterectomy
- ☐ Other

Clinical hx: _____

CYTOLOGY

Specimen Source

☐ Endocervical/Cervical ☐ Vaginal ☐ Other _____

Pap and HPV Testing

- ☐ Liquid-Based Pap (ThinPrep® or SurePath®)
- ☐ Liquid-Based Pap with HPV DNA Screening for age 30+
- ☐ Liquid-Based Pap with reflex, if ASC-US
- ☐ Liquid-Based Pap with reflex, if ASC-US or higher
- ☐ High Risk HPV DNA
- ☐ Reflex HPV-HR Genotype if HPV-HR is positive

Cervical DNA Dtex® Testing

- ☐ DNA Dtex®
- ☐ DNA Dtex® if LSIL
- ☐ DNA Dtex® if LSIL or ASC-US/HPV+
- ☐ DNA Dtex® if LSIL or HRHPV+

Today's Exam

☐ Normal ☐ Abnormal _____

☐ Concurrent Biopsy Performed

High-Risk Data

- ☐ Abnormal Pap within last 3 years
- ☐ DES Exposure
- ☐ Early onset of sexual activity
- ☐ History of STDs
- ☐ Multiple sexual partners
- ☐ No Pap last 7 yrs or <3 neg Paps

MOLECULAR TESTING

- ☐ **Chlamydia (CT) & Gonorrhea (NG) Screen**
- ☐ CT Only ☐ NG Only
- ☐ **HSV 1&2**
- ☐ HSV1 Only ☐ HSV2 Only
- ☐ **BD Affirm Vaginitis Panel (all three organisms)**
- ☐ Trichomonas Only
- ☐ Candida Only
- ☐ Gardnerella Only
- ☐ **Urogenital Mycoplasma & Ureaplasma Panel**
- ☐ **Expanded Vaginosis Panel**
- ☐ **Candida Vaginitis Panel**
- ☐ **Other**_____

(See back of requisition for Panel components if ordering separately)

NON-GYN TESTING

☐ **Halo** ☐ **Nipple Discharge**

Indicate Source

☐ Right Breast ☐ Left Breast

CULTURES

☐ Source _____

☐ Group B Strep ☐ Urine

☐ Vaginal ☐ Other _____

CYSTIC FIBROSIS

☐ CF Mutation Panel

Family History of CF? ☐ Yes ☐ No

☐ Ethnicity _____

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white - lab use 1 yellow - lab use 2 pink - client copy

THIS PAGE IS FOR REFERENCE ONLY. PLEASE USE THE FRONT OF FORM TO ORDER TESTING

All tests below may be ordered individually or as a Panel based on medical necessity.
If an individual test is preferred, please write the test name on the "Other" line on the front of the requisition.

Urogenital Mycoplasma & Ureaplasma Panel

Mycoplasma hominis
Mycoplasma genitalium
Ureaplasma urealyticum

Expanded Vaginosis Panel

B. fragilis
Gardnerella vaginalis
Mobiluncus mulieris
M. curtisii
Atopobium vaginae
P. bivia

Candida Vaginitis Panel

C. albicans
C. krusei
C. tropicalis
C. glabrata
C. parapsolis