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CYTOLOGY ORDER REQUISITION

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ASSOCIATES IN PATHOLOGY, S.C.

Patient Name (Last) (First) (MI)
 DOB _____ Male Female
 MRN _____
***Patient Label or Complete**

Physician _____
 Copy to _____
 Facility _____

***Specimen container must match requisition (Name, Source, DOB, etc.)**

Collection Date/Time _____

Cytology Gynecological Source:

- Site/Source:** Cervical Vaginal Cervical/Vaginal
 ThinPrep Conventional
 Routine Pap High Risk Pap Diagnostic Pap

LMP _____

	YES	NO
Contraceptives		
Pregnant		
Postpartum		
Hormone Replacement Therapy		
Postmenopausal		
Hysterectomy		
Abnormal Bleeding		
Gross Lesion		
Radiation Therapy (pelvic)		
Chemotherapy (any cancer)		

HPV Testing Options:

- Reflex HPV testing on (may check more than one):
 Negative AGC
 ASCUS LSIL
 ASC-H HSIL
- Regardless of diagnosis/co-testing
- Other (the clinic may contact cytology department within one week of reviewing Pap results to order HPV)
- HPV only (no Pap test)
- No HPV testing

Gonorrhea/Chlamydia Testing Options:

- Gonorrhea/Chlamydia
 Gonorrhea only
 Chlamydia only
 No Gonorrhea/Chlamydia

Other Abnormal Findings/Hx:
 Previous Abnormal Pap:

Cytology Non-Gynecological Source:

- Site/Source:**
- Urine: Voided Catheter
 Bladder Wash
 Pleural (thoracentesis) Right Left
 Peritoneal (abdominal fluid/ascites)
 Pericardial
 Pelvic Wash
 CSF
 Bronchial Brush Site: _____
 Bronchial Wash Site: _____
 Sputum
 Nipple Discharge Right Left
 Breast Cyst: Right Left _____
 Other Site: (Specify) _____

Notice to Physicians: When ordering test for Medicare and Medicaid patient, please select only the test(s) medically necessary for the dx or treatment of patient. Medicare does not pay for routine screening tests.

For office use only:

SEPARATE SHEET SHOWING PATIENT DEMOGRAPHICS INFORMATION MUST BE ATTACHED

Clinician/Practitioner/RN Signature: _____

Date: _____