

# CERVICAL/VAGINAL CYTOLOGY REQUISITION

University of Colorado Anschutz Medical Campus - Department of Pathology (Division of Cytology)

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## Ordering Clinician

Last Name: \_\_\_\_\_ UPIN #: \_\_\_\_\_

First Name: \_\_\_\_\_ Pager Number: \_\_\_\_\_

Resident / Clinic Contact Individual: Name \_\_\_\_\_

Phone # \_\_\_\_\_

## Clinic Information

AIP  ACP  AOP  Satellite  Other \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Clinic Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

## Medical Record Number:

Patient Name (Last, First, MI): \_\_\_\_\_

DOB: \_\_\_\_\_

Sex: \_\_\_\_\_

Encounter/Visit No.: \_\_\_\_\_

Referral #: \_\_\_\_\_

## Ins Payor Code:

Registered

In-Patient

Non-Registered

Out-Patient

Attach patient data sheet and insurance card

(Charges may be billed directly to client, if not provided)

Date & Time Collected: \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

## Specimen Type

Cervical  Endocervical  Vaginal

Pap Collection Method  Thin Prep

SurePath

Requested Procedure → Must Specify to Avoid Specimen Rejection

Pap Only

Pap with HPV-High Risk Testing (Reflex), if diagnosis is ASCUS

Pap with HPV-High Risk Testing Requested if Diagnosis is ASCUS or Above

Pap with HPV-High Risk Typing

HPV-High Risk Typing Only (Dysplasia Surveillance)

\*Unless HPV Testing is Clinically Indicated, Patient May Be Billed - See Consensus Guidelines ([www.asccp.org](http://www.asccp.org))

Include GC/Chlamydia to Above (Vials Only)

GC/Chlamydia Only (Vials Only)

## Previous Pap / Biopsy

Pap (Date/Result) \_\_\_\_\_

Biopsy (Date/Result) \_\_\_\_\_

Treatment \_\_\_\_\_

## Screening Factors

Pregnant

Post Partum (Nursing - Y / N )

Irregular Periods

Birth Control (Pills / Depo / Ring / IUD)

Hysterectomy (Partial / Complete)

Post Menopausal x \_\_\_\_\_ years

Hormonal Therapy

(Specify: \_\_\_\_\_)

Menopausal Symptoms

Abnormal PMP Vaginal Bleeding

DES Exposure

Smoker

History of HPV

History of STD

History of HIV

Abnormal Gyn History

(Type/Date: \_\_\_\_\_)

Doctor - Designated High Risk Patient

History of Other Malignancy

(Type/Date: \_\_\_\_\_)

Chemotherapy

Radiation Therapy

GRAV	PARA	SAB	TAB

## Visit Type

Routine Screening (V76.2)

Pregnancy (V22.2)

Post Partum (V24.2)

High Risk (V15.89)

Other (Dx Code: \_\_\_\_\_)

Diagnostic  Follow-Up Exam  
With Signs or Symptoms of Disease  
(Clinical Indication / Explanation Required)

Research Study

Study Name: \_\_\_\_\_

COMIRB #: \_\_\_\_\_

Grant #: \_\_\_\_\_

Speed Type #: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Additional Information - Patient History / Previous Diagnosis / Comments / Other

Accession Number: \_\_\_\_\_

Date / Time Received: \_\_\_\_\_

White Copy - Cytology Department

Yellow Copy - Clinic

Rev 03/11