Intermountain Health

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CLIA ID # 06D0519294

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Collection Date: _____/_____/_____ **Collection Time:** _____ AM / PM

Requesting Physician/Provider	**Address:**	**Phone/Fax:**
Copy To:		

Patient and Billing Information (Please Print) **Please provide complete billing information and include insurance card copy.**

Last Name	**First Name**	**Initial**	**Previous Name**	**Birth Date**	**Sex**

Address	**City**	**State**	**Zip**	**Phone**	**Social Security Number**

Primary Insurance Company	**Subscriber Number/ID Number**	**Group Number**

Gynecological Cytology (Pap Smear)

☐ **Routine Screening Pap Smear** (Asymptomatic patient)

☐ **Diagnostic Pap Smear** (Previous abnormal pap, high risk patient, or symptomatic patient)

Diagnosis Code(s)

GYN Cytology Tests:

☐ ThinPrep Pap® Test

☐ ThinPrep Pap® Test with HPV DNA reflex testing ***if diagnosis is "ASCUS"***

☐ With reflex to HPV genotyping

☐ ThinPrep Pap® Test with HPV DNA ***regardless of the diagnosis***

☐ With reflex to HPVgenotyping

Specimen Source:

☐ Cervical

☐ Vaginal

☐ Other_____

Clinical Information:

LMP _____/_____/_____

☐ Pregnant

☐ Postpartum

☐ Postmenopausal

☐ Hormones_____

☐ IUD Present

☐ Hysterectomy (cervix absent)

☐ Hysterectomy (cervix present)

☐ Abnormal bleeding

Previous Pap Smear:

Date: _____/_____/_____

Number/Diagnosis:_____

Non-Gynecological Cytology

Specimen Source: ☐ Sputum ☐ Urine ☐ Anal Pap ☐ Other:_____ ☐ FNA, Source:_____

Clinical History:_____

Histology / Surgical Pathology

Specimens(s):

Clinical Information:

Signature:_____Date:_____Time:_____