LAB USE ONLY

Place Accession Label Here

CYTOLOGY REQUEST

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Email: info@aipathology.com

AIP 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 requistion (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:
Diagnosis:
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/Practioner/RN Signature: _____ **Date:** _____