LAB USE ONLY

*Place Accession Label Here*

# CYTOLOGY REQUEST

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AIP ASSOCIATES IN PATHOLOGY SERVICE CORPORATION

**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 ○

○ 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:** _____