

DATE COLLECTED ____/____/____
TIME OF COLLECTION: _____

PATIENT INFORMATION				CYTOLOGY ACCESSION #:	DATE RECEIVED IN LAB:
LAST NAME		FIRST NAME		M.I.	PHYSICIAN INFORMATION:
STREET ADDRESS				APT. #	
CITY			STATE	ZIP CODE	
PHONE NUMBER					
DATE OF BIRTH / /		SEX	AGE	RACE	
ICD-10			Account #		
PLEASE ATTACH COPY OF INSURANCE CARD					

PAP SPECIMEN TEST SOURCE

Cervical/Endocervical Vaginal

MENSTRUAL STATUS (Check one)

Pregnant Amenorrhea
 Post-Menopausal Date of LMP:

PERTINENT CLINICAL HISTORY (Check one)

Negative Invasive Ca
 Atypical Dysplasia
 Ca in Situ

HORMONE THERAPY/CONTRACEPTIVES

I.U.D. Depo-Provera
 Oral Contraceptives Hormone Replacement
 None/Unknown

LAB SPECIFIC TEST CODE

Screening PAP

PAPSO Under 21 years of age ThinPrep Screen
 PAPS 21-29 years of age ThinPrep Screen with HPV Reflex
 PAP3S 30 years of age and older ThinPrep Screen with HPV

Diagnostic PAP

PAPDO Under 21 years of age ThinPrep Diagnostic
 PAPD 21-29 years of age ThinPrep Diagnostic with HPV Reflex
 PAP3D 30 years of age and older ThinPrep Diagnostic with HPV

ADDITIONAL TESTING

CGAMP *Chlamydia trachomatis* and *Neisseria gonorrhoeae* by Nucleic Acid Amplification (GEN-PROBE)
 TVRNA *Trichomonas vaginalis* by Nucleic Acid Amplification

SPECIAL NOTES: