GYNECOLOGICAL (PAP) REQUEST FORM

PHYSICIANS LABORATORY
focused on excellence

SIOUX FALLS, SD
MITCHELL, SD
SPENCER, IA
YANKTON, SD

Client Services: (605) 322-7212 • (800) 658-5474
Website: www.plpath.com

SEX	DATE OF BIRTH	DATE COLLECTED

SOCIAL SECURITY NO.

PRINT PATIENT NAME – FIRST, MIDDLE, LAST

STREET — APT. NO.

CITY — STATE — ZIP

TELEPHONE NO. ( )

RESPONSIBLE PARTY & ADDRESS (if other than patient.)

CLINIC CODE

BILL TO:

☐ SUBMITTING CLINIC ☐ PATIENT / INS ☐ MEDICARE / MEDICAID ☐ INPATIENT ☐ OUTPATIENT

MEDICARE I.D. NO.

MEDICAID (WELFARE) NO.

INSURANCE COMPANY NAME, ADDRESS

INSURED'S I.D. NO.

INSURED'S GROUP NO.

CHART NUMBER

DIAGNOSIS CODE

SUBMITTING PHYSICIAN

PHYSICIAN / PROVIDER SIGNATURE

NOTE

ADVANCE BENEFICIARY NOTICE (ABN)

** FOR MEDICARE PATIENTS **

SEE OTHER SIDE OF THIS SHEET.
PLEASE CHECK ONE CHOICE, SIGN AND DATE THE FORM!

GYNECOLOGICAL CYTOLOGY SPECIMENS

SPECIMEN SOURCE: ☐ Cx/Vag. ☐ Cx ☐ Vag.

TESTING REQUESTED – Mark **ALL** Testing Requested

☐ **Co-testing (Pap + HPV testing)**
Recommended per guidelines, for women aged 30-65
☐ Reflex to 16/18/45 if HPV positive

☐ **Pap Test**
☐ If ASC-US, perform HPV testing
☐ Reflex to 16/18/45 if HPV positive

☐ **HPV testing only**
☐ Reflex to 16/18/45 if HPV positive

☐ **C. Trachomatis testing**

☐ **N. Gonorrhea testing**

☐ **Trichomonas vaginalis testing**

STATUS OF UTERUS AND CERVIX:
☐ Both present
☐ Only Cx present
☐ Both absent

CURRENT REPRODUCTIVE STATUS (If Applicable):
☐ Pregnant ☐ Postpartum
☐ Postmenopausal

CLINICAL HISTORY:
☐ Radiation
☐ GYN Ca
☐ HPV
☐ Herpes
☐ LEEP
☐ Prior Biopsy
Hormone Tx – Type: _____

LMP: (Date):

☐ Prior Abnormal Pap
☐ Abnormal Vaginal Bleeding
☐ Other Current Symptoms _____
_____
Date _____

FOR LAB USE ONLY

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