Altru HEALTH SYSTEM

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Gynecologic
SPECIMEN FOR CYTOLOGIC DIAGNOSIS

PLEASE COMPLETE IN FULL. ***COMPLETE INSURANCE INFORMATION.

Patient Name _____

Date of Birth _____ Social Security #_____ Sex_____

MRUN/Chart #_____

Date Specimen Obtained _____

Referring Clinic/Hospital _____

Ordering Provider_____

Address _____ Phone_____

FAX Report _____Yes FAX #_____

***Insurance Information:**

Guarantor Name _____ Relationship_____ Phone (____)_____

Address_____City_____State_____ Zip_____

Medicare #_____ BC/BS#_____ND____MN____

Welfare ND____ MN____ County_____ Number _____

Other Insurance:

Subscriber _____Company_____Ins #_____

PROVIDER ORDERS

SPECIMEN SOURCE: ☐ Cervical ☐ Endocervical ☐ Vaginal

CLINICAL HISTORY: Last Menstrual Period_____

REASON FOR CYTOLOGY (check all that apply):

Thin Prep Pap
- ☐ Thin Prep Pap Screen (Routine) V76.2
- ☐ Thin Prep Pap Screen (High Risk) V15.89
- ☐ Thin Prep Pap Diagnostic (Supply Dx) _____

Previous Cytology#_____

Previous Dx (circle one): UNSAT WNL ASCUS LGSIL HGSIL Other _____

REFLEX HPV test if ASCUS result:

☐ High Risk Probe (V73.81)

HPV only

☐ Human Papillomavirus (Thin Prep Vial Only)

☐ High Risk Probe (V73.81)

Clinical History
- ☐ Abnormal bleeding/spotting
- ☐ Menopausal/Post/Peri
- ☐ Post Partum
- ☐ Postmenopausal bleeding
- ☐ Pregnant

Previous Procedures
- ☐ Chemotherapy/Radiation therapy
- ☐ Conization/LEEP
- ☐ Cryosurgery/Laser treatment
- ☐ Other_____
- ☐ Supracervical hysterectomy
- ☐ Total hysterectomy with OOPH
- ☐ Total hysterectomy without OOPH

Hormonal/Contraceptive Use
- ☐ Birth Control Pill
- ☐ Depo Provera
- ☐ Estrogen replacement
- ☐ Hormonal vaginal ring
- ☐ IUD
- ☐ Other hormones _____

REQUIRED: Ordering Provider

_____
Signature

Date:_____

Time:_____

Gynecologic
Specimen for cytologic diagnosis

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