

Facility Name

Facility Address

Provider Full Name

Provider NPI

STAT DUPLICATE REPORT TO:

GYNECOLOGICAL CYTOLOGY REQUEST		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	RACE	SEX
SOCIAL SECURITY NUMBER		
PATIENT ID#		

BILLING INFORMATION	
PATIENT ADDRESS	APT. #
CITY	STATE ZIP
HOME PHONE#	WORK PHONE#
BILL TO (PLEASE SELECT)	
<input type="checkbox"/> DOCTOR <input type="checkbox"/> PATIENT <input type="checkbox"/> CHP <input type="checkbox"/> MCR <input type="checkbox"/> MCD <input type="checkbox"/> OTHER	
PRIMARY INSURANCE NAME	

ADDRESS	
INSURED NAME	
ID #	GROUP #

LAB USE ONLY	
<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> SAT <input type="checkbox"/> ADEQUATE T-ZONE <input type="checkbox"/> UNSAT <input type="checkbox"/> INSUFF. T-ZONE
	PREV: BX:
CYTOTECH/DATE	
<input type="checkbox"/> AGREE WITH CYTOTECH	

SPECIMEN INFORMATION
DATE TAKEN: _____ / _____ / _____
SPECIMEN SOURCE (REQUIRED)
<input type="checkbox"/> CERVIX <input type="checkbox"/> VAGINAL <input type="checkbox"/> ENDOCERVIX <input type="checkbox"/> OTHER
LIQUID BASED PAP ANCILLARY TESTS BY PCR:
<input type="checkbox"/> WOMEN < AGE 30 (PAP ONLY) - REFLEX TO HIGH RISK HPV: <input type="checkbox"/> IF ASCUS <input type="checkbox"/> IF ABNORMAL <input type="checkbox"/> WOMEN ≥ AGE 30 (HIGH RISK HPV + PAP) <input type="checkbox"/> HIGH RISK HPV REGARDLESS <input type="checkbox"/> HIGH RISK HPV ONLY - NO PAP <input type="checkbox"/> CHLAMYDIA & G.C. <input type="checkbox"/> TRICHOMONAS
<small>ALL HIGH RISK HPV TESTING INCLUDES GENOTYPING (16/18) WHEN PERFORMED AT KWB LAB</small>
SWAB OR URINE ANCILLARY TESTS BY PCR:
<input type="checkbox"/> STI PANEL (INCLUDES ALL LISTED BELOW) <input type="checkbox"/> CHLAMYDIA & G.C. <input type="checkbox"/> TRICHOMONAS <input type="checkbox"/> M. GENITALIUM

CLINICAL INFORMATION
ICD-10 CODES - REQUIRED
<input type="checkbox"/> Z12.4 CERVIX (ROUTINE CERVICAL PAP TEST) <input type="checkbox"/> Z01.419 ROUTINE GYN EXAM <input type="checkbox"/> Z12.72 SPECIAL SCREENING FOR MALIGNANT NEOPLASM, VAGINA <input type="checkbox"/> Z87.42 PREVIOUS ABNORMAL PAP TEST <input type="checkbox"/> Z87.410 HISTORY OF CERVICAL DYSPLASIA <input type="checkbox"/> OTHER: _____
LMP: _____ / _____ / _____
<input type="checkbox"/> PREGNANT <input type="checkbox"/> HORMONE REPLACEMENT THERAPY <input type="checkbox"/> POST PARTUM <input type="checkbox"/> BIRTH CONTROL PILLS <input type="checkbox"/> POST MENOPAUSAL <input type="checkbox"/> DEPOPROVERA <input type="checkbox"/> ABNORMAL BLEEDING <input type="checkbox"/> IUD <input type="checkbox"/> HYSTERECTOMY <input type="checkbox"/> BIRTH CONTROL RING <input type="checkbox"/> HPV VACCINE <input type="checkbox"/> RADIATION THERAPY/DATE: _____

HISTORY OF ABNORMAL PAP / BX	<input type="checkbox"/> YES <input type="checkbox"/> NO
LAST PAP TEST:	DATE: _____ PATH#: _____
DIAGNOSIS:	_____
CLINICAL DIAGNOSIS:	_____

FOR BARCODE LABEL ONLY
