



		BILLING		Specimen Date		Specimen Time									
		<input type="checkbox"/> PHYSICIAN ACCOUNT <input type="checkbox"/> PATIENT ACCOUNT		Mo	Day	Yr									
		Patient Name (First)		(Last)		(M.I.)									
		Patient I.D. Number		Mo	Day	Yr	Yrs	Age Mo	Sex M F						
Social Security #		Physician / Provider I.D.													
REQUIRED CERVICO VAGINAL CYTOLOGY INFORMATION															
<input type="checkbox"/> SCREENING PAP - LOW RISK PATIENT <input type="checkbox"/> SCREENING PAP - HIGH RISK PATIENT (SEE BELOW) <input type="checkbox"/> DIAGNOSTIC PAP (SEE BELOW)															
FILL OUT INSURANCE INFORMATION OR ATTACH INFORMATION				SPECIMEN SOURCE(S)				COLLECTION METHOD							
Responsible Party or Insured's Name (Last, First)								<input type="checkbox"/> CERVICAL				<input type="checkbox"/> ENDOC BRUSH			
Address								<input type="checkbox"/> ENDOCERVICAL				<input type="checkbox"/> CERVIX BROOM			
City, State, Zip								<input type="checkbox"/> VAGINAL				<input type="checkbox"/> PLASTIC SPATULA			
Medicaid Number/HMO Number								<input type="checkbox"/> VULVA/LABIA				<input type="checkbox"/> OTHER: _____			
Workers Comp. <input type="checkbox"/> Yes <input type="checkbox"/> No								<input type="checkbox"/> OTHER: _____							
Medicare Number								CLINICAL HISTORY							
Medicare Type <input type="checkbox"/> Regular <input type="checkbox"/> Railroad <input type="checkbox"/> UMW								LMP DATE _____				<input type="checkbox"/> PRIOR HYSTERECTOMY			
Insurance Company								<input type="checkbox"/> PREGNANT				<input type="checkbox"/> ESTROGEN			
Insurance Subscriber No.								<input type="checkbox"/> POST PARTUM				<input type="checkbox"/> BC "PILL"			
Patient Illness/Sign or Symptom Code (ICD - 9 Code)								<input type="checkbox"/> MENOPAUSAL				<input type="checkbox"/> IUD			
								<input type="checkbox"/> POST MENOPAUSAL				<input type="checkbox"/> RADIATION			
												<input type="checkbox"/> CHEMO			
HIGH RISK / DIAGNOSTIC PAP															
POSITIVE HISTORY				POSITIVE CLINICAL FINDINGS				OTHERS - GIVE DETAILS:							
<input type="checkbox"/> PREVIOUS ABNORMAL PAP				<input type="checkbox"/> ABN BLEEDING				_____							
DATE: _____ LAB: _____				<input type="checkbox"/> VAGINITIS				_____							
<input type="checkbox"/> PREVIOUS ABNORMAL BIOPSY				<input type="checkbox"/> CERVICITIS				_____							
DATE: _____ LAB: _____				<input type="checkbox"/> DISCHARGE				_____							
<input type="checkbox"/> NO PAP IN LAST 3 YRS				<input type="checkbox"/> VISIBLE LESION OR MASS				_____							
<input type="checkbox"/> HIGH RISK PERSONAL HISTORY															
SPECIMEN TYPE-PLEASE MARK APPROPRIATE BLOCK(S)						ANATOMIC LOCATION (CHECK ALL APPLICABLE BOXES)									
<input type="checkbox"/> CATH URINE		<input type="checkbox"/> PERICARDIAL		<input type="checkbox"/> PELVIC WASH		<input type="checkbox"/> NIPPLE SMEAR		<input type="checkbox"/> SPUTUM		<input type="checkbox"/> RIGHT		<input type="checkbox"/> UPPER LOBE		<input type="checkbox"/> LOWER LOBE	
<input type="checkbox"/> VOIDED URINE		<input type="checkbox"/> PERITONEAL		<input type="checkbox"/> CSF		<input type="checkbox"/> OTHER (LIST) _____		<input type="checkbox"/> P.B. SPUTUM		<input type="checkbox"/> LEFT		<input type="checkbox"/> MIDDLE LOBE		<input type="checkbox"/> _____	
<input type="checkbox"/> BLADDER		<input type="checkbox"/> PLEURAL		<input type="checkbox"/> GI (SPECIFY) _____				<input type="checkbox"/> BRONCH WASH							
<input type="checkbox"/> KIDNEY		<input type="checkbox"/> ABDOMEN						<input type="checkbox"/> BRONCH BRUSH							
FNA SPECIMENS				BREAST				NECK				OTHER or additional History			
# OF SLIDES _____				<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT								_____			
<input type="checkbox"/> SOLID MASS				MARK SITE OF LESION								_____			
<input type="checkbox"/> CYSTIC MASS												_____			
<input type="checkbox"/> PREVIOUS MALIGNANCY												_____			
CLINICAL HISTORY				BIOPSY - LIST TYPE OF TISSUE / PROCEDURE AND EXACT ANATOMIC SITE											

