Associated Pathology Medical Group

APMG

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WOMEN'S HEALTH/BIOPSY
Cytology/Histology

PATIENT INFORMATION

Last Name | First Name | M.I.

Date of Birth / / | Specimen Date / / | Sex M F | MRN #

Patient Social Security Number | Patient Phone Number

Street Address | Apt. #

City | State | Zip

CLIENT INFORMATION

Special Handling

○ Phone ○ Fax (_____) _____ ○ CC _____ Physician's Signature _____

BILLING INFORMATION Attach copy of all insurance I.D. cards (front and back, please)

Bill To: ○ Patient ○ Doctor ○ HMO ○ Insurance ○ Medicare/Medi-Cal # _____

Subscriber Name — Relationship to Subscriber: ○ Self ○ Spouse ○ Dependent ○ Other _____

Insurance Name | Address | City, State, Zip

ID # | Group #

Subscriber DOB: | Subscriber Sex: ○ Male ○ Female

○ Medicare patient reviewed and signed advanced beneficiary notice for non-covered services

ICD-10 Code (Required) ○ Routine ○ High-Risk Diagnosis Code(s) _____

GYN CYTOLOGY

Pap Test (See supplies for Specimen Info)

○ ThinPrep® Pap, reflex HPV on ASC-US and above*
○ ThinPrep® Pap, reflex HPV on ASC-US only*
○ ThinPrep® Pap with HPV* (Recommended for women 30+)
○ ThinPrep® Pap only
○ SurePath® Pap, reflex HPV on ASC-US and above*
○ SurePath® Pap, reflex HPV on ASC-US only*
○ SurePath® Pap with HPV* (Recommended for women 30+)
○ SurePath® Pap only
○ HPV only (no Pap*)
○ Conventional Pap

**High-risk HPV includes HPV 16/18 genotyping (cobas® assay).*

SPECIMEN SOURCE: ○ Cervical/Endocervical ○ Cervical ○ Vaginal ○ Other _____

Tests from BD AFFIRM VPIII KIT
○ Candida
○ Trichomonas
○ Gardnerella

Tests from (Circle one):
SurePath® **ThinPrep®**
_____ Chlamydia & Gonorrhea
_____ Chlamydia only
_____ Gonorrhea only

CLINICAL INFORMATION

Last Menstrual Period: _____/_____/_____

○ Routine Check-up
○ Repeat/Follow-up
○ Pregnant (wks. _____)
○ Postpartum (wks. _____)
○ Postmenopausal
○ Total Hysterectomy
○ Sub-total Hysterectomy (cervix present)
○ Oral Contraceptives
○ Depo Provera
○ Hormonal Replacement Therapy
○ IUD
○ HPV/LGSIL/HGSIL
○ Cryo/Laser/LEEP/Cone
○ Abnormal Bleeding
○ Previous Malignancy/Type
○ Radiation/Chemotherapy
○ Immunosuppressed
○ Other _____

PREVIOUS	PAP	BIOPSY
Date		
Accession No./Lab		
Diagnosis		

NON-GYN CYTOLOGY

Specimen Source:

URINE: ○ Voided ○ Cath ○ Bladder Wash ○ UroVysion™

○ Sputum
○ Nipple Discharge
○ Body Cavity Fluids (specify source) _____
○ Fine Needle Aspiration (specify source) _____
○ Other (specify) _____

No. of Smears: ○ Air Dried _____ ○ Fixed _____

HISTOLOGY (TISSUE BIOPSIES)

Clinical History / Clinical Diagnosis:

_____

_____

_____

Tissue Submitted (list site)

○ Cervix _____
○ LEEP
○ ECC _____
○ Endometrium
○ POC _____
○ TAB
○ Skin Tag _____
○ Other

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LAB USE ONLY ○ DS ○ SP ○ APMG ○ CUL ○ REMEL ○ VPIII