



APMG

Associated Pathology Medical Group

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WOMEN'S HEALTH/BIOPSY

Cytology/Histology

PATIENT INFORMATION			CLIENT 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		

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* SurePath® Pap, reflex HPV on ASC-US and above*
 ThinPrep® Pap, reflex HPV on ASC-US only* SurePath® Pap, reflex HPV on ASC-US only*
 ThinPrep® Pap with HPV* (Recommended for women 30+) SurePath® Pap with HPV* (Recommended for women 30+)
 ThinPrep® Pap only 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 Postmenopausal Depo Provera Abnormal Bleeding
 Repeat/Follow-up Total Hysterectomy Hormonal Replacement Therapy Previous Malignancy/Type
 Pregnant (wks. ____)
 Postpartum (wks. ____)
 Sub-total Hysterectomy (cervix present) IUD Radiation/Chemotherapy
 Oral Contraceptives HPV/LGSIL/HGSIL Immunosuppressed
 Cryo/Laser/LEEP/Cone Other _____

PREVIOUS	PAP	BIOPSY	HISTOLOGY (TISSUE BIOPSIES)
Date			Clinical History / Clinical Diagnosis: _____ _____ _____
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 _____

Tissue Submitted (list site)

Cervix
 LEEP
 ECC
 Endometrium
 POC
 TAB
 Skin Tag
 Other _____

LAB USE ONLY DS SP APMG CUL REMEL VPIII