DATE OF SERVICE	PATIENT **LAST** NAME **PLEASE PRINT**	PATIENT **FIRST** NAME	PATIENT M.I.	SLIDE ACCESSION NO.
BIRTHDATE (REQUIRED)	SEX - M/F	MRN/PATIENT ID/CHART #	PHONE	MLA PATIENT CODE

STREET

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER (SSN)

BILL TO: ☐ **PATIENT** ☐ **DOCTOR** ☐ **THIRD PARTY**

MEDICARE PATIENTS – REVIEW AND SIGN ADVANCE BENEFICIARY NOTICE (ABN) ON BACK OF REQUISITION, OR ATTACH COPY OF ABN.

PLEASE ATTACH INSURANCE CARD OR COMPLETE LINES BELOW

REFERRING PROVIDER SIGNATURE

PRIMARY INSURANCE / MEDICARE / MEDICAID	SECONDARY INSURANCE
INSURANCE COMPANY	INSURANCE COMPANY
INSURANCE ADDRESS	INSURANCE ADDRESS
SUBSCRIBER'S NAME (IF OTHER THAN PATIENT)	SUBSCRIBER'S NAME (IF OTHER THAN PATIENT)
GROUP #	GROUP #
SUBSCRIBER ID / SSN	SUBSCRIBER ID / SSN

SURGICAL PATHOLOGY AND CYTOLOGY REQUISITION

PAP SPECIMEN

☐ **SCREENING PAP** _____ICD 10

☐ **DIAGNOSTIC PAP**

SPECIMEN SOURCE

☐ **CERVIX** ☐ **VAGINA**

☐ **ENDOCERVIX**

HPV TESTING

☐ **REFLEX HPV TESTING IF ASCUS**

☐ **HPV SCREEN IF AGE 30-64**

☐ **HPV TESTING REGARDLESS OF PAP RESULT (ICD 10 REQUIRED)**

☐ **HPV TESTING ONLY (ICD 10 REQUIRED) (NO PAP ORDERED)**

☐ **REFLEX HR HPV POSITIVE TO 16+18/45 GENOTYPING** _____ICD 10

MOLECULAR MICROBIOLOGY

☐ **CHLAMYDIA**

☐ **GONORRHEA**

SOURCE: ☐ **PAP VIAL** ☐ **CERVIX/ENDO/VAGINA** ☐ **URINE** ☐ **URETHRA**

_____ICD 10

☐ **AFFIRM TESTING TIME:** _____ _____ICD 10

(Includes Gardnerella, Candida, and Trichomonas)

NON-GYN and / or HISTOPATHOLOGY SPECIMENS

ICD 10 DIAGNOSIS REQUIRED PER SITE	ICD 10 CODE:
☐ **CERVICAL BIOPSY: PLEASE CORRELATE WITH PRIOR PAP**	
SOURCE:	
CLINICAL DX:	

CURRENT CLINICAL INFORMATION

LMP_____

☐ **BIRTH CONTROL PILLS** ☐ **PREGNANT** ☐ **PERIMENOPAUSE** ☐ **HERPES**

☐ **LOW DOSE ESTROGEN** ☐ **POST PARTUM** ☐ **POST MENOPAUSE** ☐ **TRICHOMONAS**

☐ **DEPO PROV/DMPA** ☐ **POST ABORTION** ☐ **SPOTTING** ☐ **VAGINITIS**

☐ **IUD** ☐ **POST MENO BLEEDING**

PROCEDURE HISTORY

☐ **ENDOMETRIAL ABLATION** ☐ **LEEP** ☐ **CRYOTHERAPY**

☐ **PARTIAL/SUPRA CX HYSTERECTOMY** ☐ **CONE** ☐ **CHEMOTHERAPY**

☐ **TOTAL HYSTERECTOMY** ☐ **RADIATION THERAPY**

CLINICAL HISTORY

☐ **PATIENT AT INCREASED CLINICAL RISK FOR HPV**

☐ **PREV. ABNORMAL PAP:** _____

☐ **PREV. ABNORMAL Hx:** _____

☐ **HX OF CANCER: TYPE** _____ **SITE** _____

PAST RECORD

INTERPATH LABORATORY

19505 52nd Ave W Suite A
Lynnwood, WA 98036

PATHOLOGISTS
Reginald Wilson, M.D.
Jane Yin, M.D.

PHONE (206) 623-3814
TOLL FREE (800) 676-3814
FAX (206) 623-4327

PATIENT NAME | PATIENT NAME | PATIENT NAME | PATIENT NAME | PATIENT NAME