

CYTOLOGY LABORATORY • 1402 S. GRAND BLVD., ST. LOUIS, MO 63104 • P: 314-577-8696 • F: 314-577-8698

REQUESTING LOCATION:	COLLECTION DATA:		
SUBMITTING LOCATION:	NAME:		
ATTENDING PHYSICIAN:	IDX MRN #:	DOB:	DIAGNOSIS CODE:

GYN PAP

SPECIMEN SOURCE: (CHECK ALL THAT APPLY)

- VAGINAL WALL CERVIX ENDOCERVIX OTHER

PAP TEST: (CHECK ALL THAT APPLY)

- 88175 IMAGE ASSISTED THINPREP® PAP
 88142 NON-IMAGE ASSISTED THINPREP® PAP
 88164 CONVENTIONAL PAP SMEAR

ANCILLARY TEST: (CHECK ALL THAT APPLY)

- 87621 HIGH RISK HPV
 87621 REFLEX HIGH RISK HPV - ASCUS DIAGNOSIS ONLY
 87661 T. VAGINALIS
 87591 N. GONORRHOEAE
 87491 C. TRACHOMATIS

CLINICAL INFORMATION: (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> Z01.419 ROUTINE PAP SMEAR | <input type="checkbox"/> HORMONE THERAPY: _____ |
| <input type="checkbox"/> Z01.411 ROUTINE PAP SMEAR WITH ABNORMAL FINDINGS | <input type="checkbox"/> RADIATION THERAPY: _____ |
| <input type="checkbox"/> MENSTRUAL STATUS: LMP (REQUIRED) _____ | <input type="checkbox"/> CHEMOTHERAPY: _____ |
| <input type="checkbox"/> PREGNANT <input type="checkbox"/> POSTPARTUM <input type="checkbox"/> IUD <input type="checkbox"/> POSTMENOPAUSAL | <input type="checkbox"/> PREVIOUS ABNORMAL PAP/BIOPSY: _____ |
| <input type="checkbox"/> HYSTERECTOMY | <input type="checkbox"/> PREVIOUS CANCER DIAGNOSIS: _____ |
| <input type="checkbox"/> BIRTH CONTROL | <input type="checkbox"/> OTHER HISTORY/SYMPTOMS: _____ |

NON GYN / FNA

RESPIRATORY	FLUIDS	URINE	GASTROINTESTINAL TRACT
<input type="checkbox"/> SPUTUM	<input type="checkbox"/> PERICARDIAL FLUID	<input type="checkbox"/> BLADDER (CATHERIZED)	<input type="checkbox"/> ESOPHAGEAL BRUSH
<input type="checkbox"/> BRONCHIAL BRUSH	<input type="checkbox"/> PERITONEAL FLUID	<input type="checkbox"/> BLADDER (VOIDED)	<input type="checkbox"/> GASTRIC BRUSH
<input type="checkbox"/> BRONCHIAL LAVAGE	<input type="checkbox"/> PERITONEAL WASH	<input type="checkbox"/> BLADDER (WASH)	CENTRAL NERVOUS SYSTEM
<input type="checkbox"/> BRONCHIAL WASH	<input type="checkbox"/> PLEURAL FLUID	<input type="checkbox"/> RENAL PELVIS	<input type="checkbox"/> CEREBROSPINAL FLUID
<input type="checkbox"/> OTHER: SPECIFY SOURCE(S)		<input type="checkbox"/> FINE NEEDLE ASPIRATION (FNA): SPECIFY SOURCE(S)	

PATIENT HISTORY:

OPERATIVE PROCEDURE:

OPERATIVE FINDINGS:

POST-OP DIAGNOSIS: