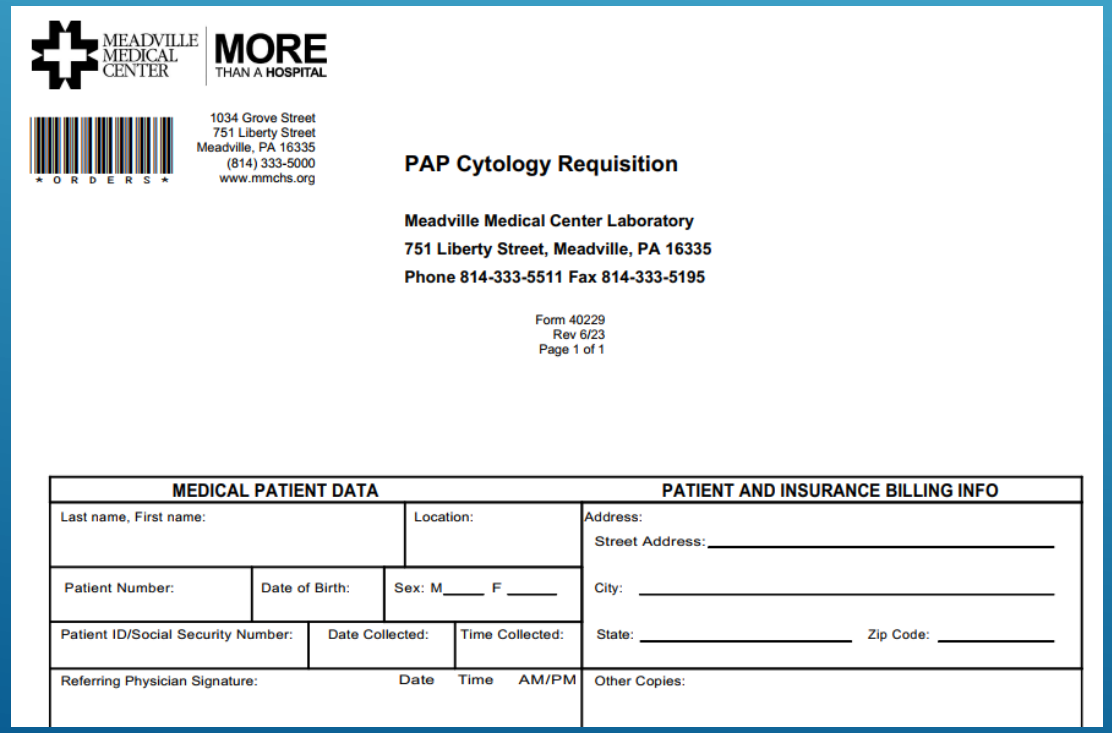
COMPLETION OF GYN/CYTO PAP FORM

Laboratory Education for Physician Office Staff

October 2024

Completion of Form

ALL REQUESTED INFORMATION MUST BE **PROVIDED** AND **LEGIBLE**



MEADVILLE MEDICAL CENTER | MORE THAN A HOSPITAL

1034 Grove Street
751 Liberty Street
Meadville, PA 16335
(814) 333-5000
www.mmchs.org

* O R D E R S *

PAP Cytology Requisition

Meadville Medical Center Laboratory
751 Liberty Street, Meadville, PA 16335
Phone 814-333-5511 Fax 814-333-5195

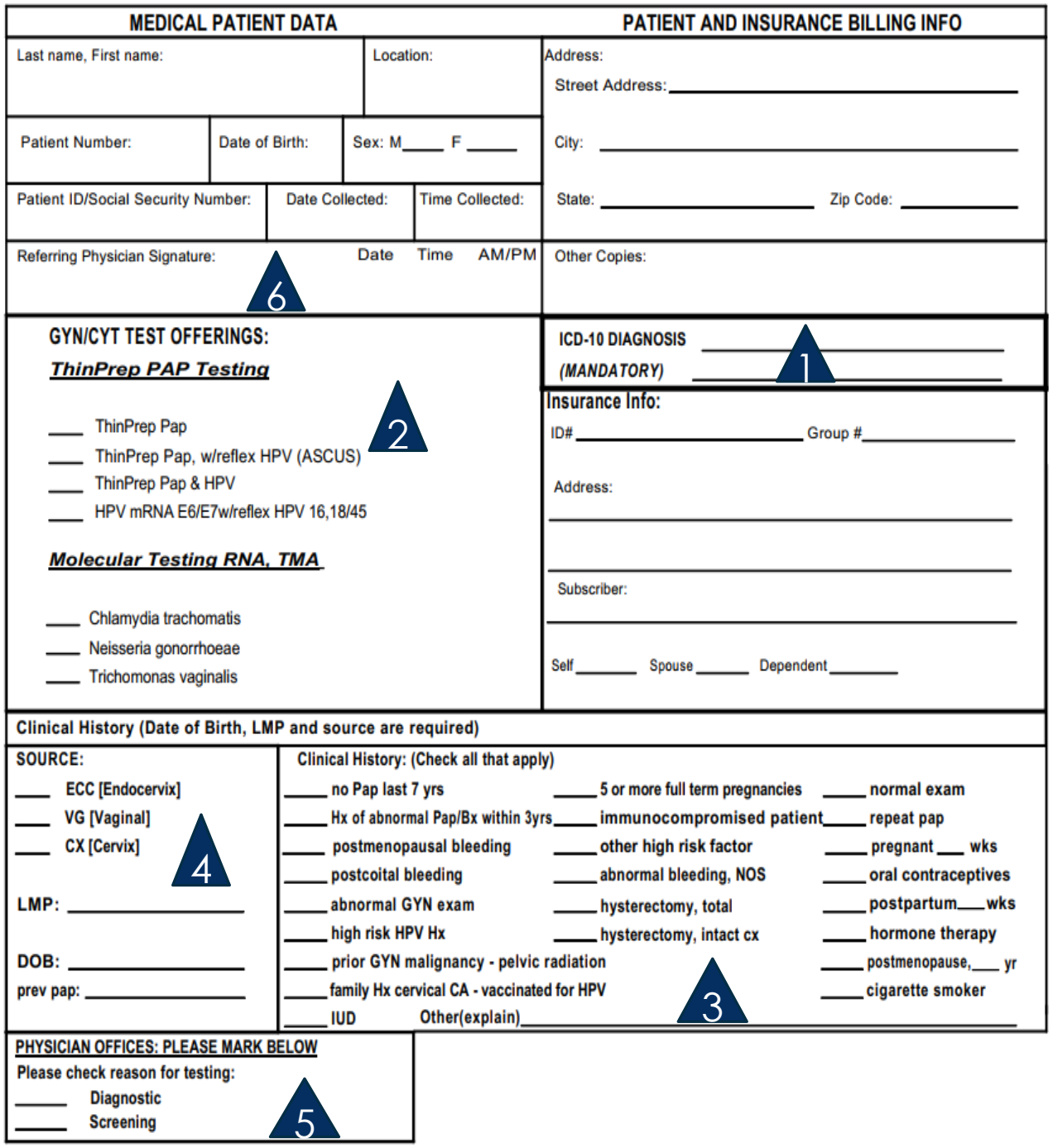
Form 40229
Rev 6/23
Page 1 of 1

MEDICAL PATIENT DATA			PATIENT AND INSURANCE BILLING INFO
Last name, First name:		Location:	Address: Street Address:
Patient Number:	Date of Birth:	Sex: M F	City:
Patient ID/Social Security Number:	Date Collected:	Time Collected:	State: Zip Code:
Referring Physician Signature: Date Time AM/PM			Other Copies:

If received specimen is not correctly labeled or request form is not complete, the specimen will be rejected and returned to office for correction.

Attaching a patient demographic data sheet is acceptable. Please verify that all requested information is present and labeled on the demographic sheet.

When attaching a demographic sheet, please write the patient name on the lab form, matching the name on sheet provided.
This ensures proper identification of lab order.



MEDICAL PATIENT DATA

Last name, First name:

Location:

Patient Number:

Date of Birth:

Sex: M____ F ____

Patient ID/Social Security Number:

Date Collected:

Time Collected:

Referring Physician Signature:

Date Time AM/PM

PATIENT AND INSURANCE BILLING INFO

Address:

Street Address: _____

City: _____

State: _____ Zip Code: _____

Other Copies:

GYN/CYT TEST OFFERINGS:

ThinPrep PAP Testing

____ ThinPrep Pap

____ ThinPrep Pap, w/reflex HPV (ASCUS)

____ ThinPrep Pap & HPV

____ HPV mRNA E6/E7w/reflex HPV 16,18/45

Molecular Testing RNA, TMA

____ Chlamydia trachomatis

____ Neisseria gonorrhoeae

____ Trichomonas vaginalis

ICD-10 DIAGNOSIS _____

(MANDATORY) _____

Insurance Info:

ID# _____ Group #_____

Address:

_____

_____

Subscriber:

_____

Self_____ Spouse_____ Dependent_____

Clinical History (Date of Birth, LMP and source are required)

SOURCE:

____ ECC [Endocervix]

____ VG [Vaginal]

____ CX [Cervix]

LMP: _____

DOB: _____

prev pap: _____

Clinical History: (Check all that apply)

____ no Pap last 7 yrs	____ 5 or more full term pregnancies	____ normal exam
____ Hx of abnormal Pap/Bx within 3yrs	____ immunocompromised patient	____ repeat pap
____ postmenopausal bleeding	____ other high risk factor	____ pregnant ___ wks
____ postcoital bleeding	____ abnormal bleeding, NOS	____ oral contraceptives
____ abnormal GYN exam	____ hysterectomy, total	____ postpartum___wks
____ high risk HPV Hx	____ hysterectomy, intact cx	____ hormone therapy
____ prior GYN malignancy - pelvic radiation		____ postmenopause,___ yr
____ family Hx cervical CA - vaccinated for HPV		____ cigarette smoker
____ IUD	Other(explain)_____	

PHYSICIAN OFFICES: PLEASE MARK BELOW

Please check reason for testing:

_____ Diagnostic

_____ Screening

Complete the following

1. ICD- 10 Diagnosis code
2. Tests requested, including HPV or Molecular testing requested
3. Clinical History
4. Source, Last Menstrual Period (LMP), Date of Birth (DOB), Date of previous pap
5. Reason for testing: Diagnostic or Screening
6. Signature from ordering physician, PA-C, or CRNP

Packaging for Transport

Prepare for transport by placing the following in a biohazard transport bag. Please place completed form in the outer pouch away from the specimen.

- MMC Cyto/PAP requisition
- Specimen labeled with patient name and DOB

Specimen may be stored at room temp until transported.