LOGAN HEALTH MEDICAL CENTER

CYTOLOGY REQUISITION

PATHOLOGY DEPARTMENT
310 Sunnyview Lane | Kalispell, MT 59901 | (406) 751-5762 | (406) 758-7064 fax

Place patient label stamp here:

IMPORTANT NOTE:

- **1 Requisition Per Patient**
- **Document Source required on the Specimen Label and the Requisition**

Use For CYTOLOGY Orders ONLY

Last Name	First Name	MI	Birthdate

Street Address	Apt #

City	State	Zip

Telephone	Sex
	M F

GUARANTOR NAME	Relationship to Patient Self Spouse Parent Other

Street	City	State	Zip

Insurance Co.	Policy #	Group #

Address	

Bill Physician Bill Patient Medicaid Medicare	Medicaid/Medicare #

Submitting Provider Signature

Printed Name

Copies to:

Collection Date / Initials:	Accession Number
Date Received:	

GYN CYTOLOGY

☐ Routine Screen ☐ High Risk Patient Screen ☐ Diagnostic
*Please use Medicare guidelines ICD-9:

AUTOCYTE PAP TEST

☐ **Pap Only**

☐ **Pap with Reflex HPV for:** ☐ ASCUS, ASC-H ☐ LGSIL ☐ Reactive Changes

☐ **Pap and HPV Test** (HPV performed irrespective of pap result)

☐ **HPV Test Only** (no pap test will be performed)

☐ **GC/Chlamydia** ☐ **GC only** ☐ **Chlamydia only**

☐ **GC/Chlamydia test only** (no pap test will be performed)

Specimen Source: ☐ Vaginal ☐ Cervical ☐ Endocervical ☐ Other

CLINICAL HISTORY:

LMP (mm/dd/yyyy) _____

☐ IUD ☐ BCP ☐ Abnormal Bleeding
☐ Pregnant_____wks ☐ Estrogen Therapy
☐ Post-partum_____wks ☐ Post Menopausal
☐ Breast feeding ☐ Radiation Therapy
☐ Hysterectomy ☐ TAH ☐ BSO ☐ Partial
☐ No Previous Abnormal Cytology
☐ Atypical squamous cells, undetermined significance
☐ Atypical glandular cells, undetermined significance
☐ Low grade squamous intraepithelial lesion
☐ High grade squamous intraepithelial lesion

Additional History:

NON-GYN CYTOLOGY

SPECIMEN SOURCE:

URINE CYTOLOGY ☐ VOIDED ☐ CATHETERIZED ☐ BARBOTAGE

PROCEDURE PERFORMED:

CLINICAL INFORMATION:

When ordering tests for which Medicare reimbursement will be sought, physicians or provider shall only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. The provider's signature is required by CMS.

Important Note: Please provide pertinent clinical history, clinical impression and physical findings (size, appearance, duration, location of a lesion), imaging and laboratory studies, etc., as they may affect the pathologic diagnosis in some situations.

WHITE - Lab • • **2nd - Clinic/Surgery**