GYNECOLOGICAL (PAP) REQUEST FORM

SIOUX FALLS, SD
MITCHELL, SD
SPENCER, IA
YANKTON, SD

Client Services: (605) 322-7212 • (800) 658-5474
Website: www.plpath.com

SEX	DATE OF BIRTH	DATE COLLECTED

SOCIAL SECURITY NO.

PRINT PATIENT NAME – FIRST, MIDDLE, LAST

STREET | APT. NO.

CITY | STATE | ZIP

TELEPHONE NO. ( ) | RESPONSIBLE PARTY & ADDRESS (if other than patient.)

CLINIC CODE

BILL TO:
☐ SUBMITTING CLINIC ☐ PATIENT / INS ☐ MEDICARE / MEDICAID ☐ INPATIENT ☐ OUTPATIENT

MEDICARE I.D. NO. | MEDICAID (WELFARE) NO.

INSURANCE COMPANY NAME, ADDRESS

INSURED'S I.D. NO. | INSURED'S GROUP NO.

CHART NUMBER | DIAGNOSIS CODE

SUBMITTING PHYSICIAN

PHYSICIAN / PROVIDER SIGNATURE

NOTE

ADVANCE BENEFICIARY NOTICE (ABN)

** FOR MEDICARE PATIENTS **

SEE OTHER SIDE OF THIS SHEET.
PLEASE CHECK ONE CHOICE, SIGN AND DATE THE FORM!

GYNECOLOGICAL CYTOLOGY SPECIMENS

SPECIMEN SOURCE: ☐ Cx/Vag. ☐ Cx ☐ Vag.

TESTING REQUESTED – Mark **ALL** Testing Requested

- ☐ **Co-testing (Pap + HPV testing)**
  Recommended per guidelines, for women aged 30-65
  - ☐ Reflex to 16/18/45 if HPV positive
- ☐ **Pap Test**
  - ☐ If ASC-US, perform HPV testing
    - ☐ Reflex to 16/18/45 if HPV positive
- ☐ **HPV testing only**
  - ☐ Reflex to 16/18/45 if HPV positive
- ☐ **C. Trachomatis testing**
- ☐ **N. Gonorrhea testing**
- ☐ **Trichomonas vaginalis testing**

STATUS OF UTERUS AND CERVIX:
- ☐ Both present
- ☐ Only Cx present
- ☐ Both absent

CURRENT REPRODUCTIVE STATUS (If Applicable):
- ☐ Pregnant
- ☐ Postpartum
- ☐ Postmenopausal

CLINICAL HISTORY:
- ☐ Radiation
- ☐ GYN Ca
- ☐ HPV
- ☐ Herpes
- ☐ LEEP
- ☐ Prior Biopsy

LMP: (Date):

- ☐ Prior Abnormal Pap
- ☐ Abnormal Vaginal Bleeding
- ☐ Other Current Symptoms ____________

Date ____________

Hormone Tx – Type: ____________

FOR LAB USE ONLY

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