CLINICAL PATHOLOGY ASSOCIATES

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Patient Name: Last _____ First _____ MI _____

Patient Address: _____ City, State, Zip: _____

Patient SS#: _____ Date of Birth: _____ Sex: _____

Phone # _____ Alt. Phone # _____

Requesting Physician REQUIRED	Hospital / Clinic REQUIRED	Date Collected REQUIRED	Chart #

PLEASE COMPLETE INFORMATION BELOW

BILLED TO ☐ AETNA ☐ CIGNA ☐ MEDICAID ☐ PHYSICIAN/CLINIC ☐ UHC
☐ BC/BS ☐ FIRST CARE ☐ MEDICARE* ☐ PATIENT ☐ OTHER INS. _____

Medicare/Medicaid/Insurance Policy #	Group
Insured Name (Attach Card) Relationship: ☐ Self ☐ Spouse ☐ Dependent REQUIRED	Insured Employer REQUIRED
Insurance Co. Name & Address REQUIRED	City, State, Zip REQUIRED

GYN-CYTOLOGY

SOURCE CHECK (✓)
☐ Cervical/Endocervical ☐ Vaginal Cuff ☐ Other_____

LMP ____/____/____
LAST MENSTRUAL PERIOD

TESTS

GYN (PAP) CYTOLOGY (CHOOSE ONE)
For cervical cancer screening (Z12.4)
☐ ThinPrep
☐ ThinPrep with Imaging
☐ Conventional 1 Slide Pap

AGE BASED (PAP) TESTING (CHOOSE ONE)
☐ HPV if Pap is ASCUS (Ages 21-29)
☐ HPV if Pap is ASCUS, AGCUS, LGSIL, or HIGHER
☐ HPV Regardless (Ages 30-65)
Z11.51 screening

PAP ADD-ON TESTS
☐ Chlamydia/Gonorrhea (CT/GC)
Z11.3 screening if age <25
☐ Trichomonas (TV)

APTIMA URETHRAL SWAB (WHITE) **(MALE ONLY)**
☐ Chlamydia/Gonorrhea (CT/GC)
Z11.3 screening if age <25
☐ Mycoplasma genitalium (MG)
☐ Trichomonas (TV)

APTIMA URINE COLLECTION (YELLOW) **(FEMALE & MALE)**
☐ Chlamydia/Gonorrhea (CT/GC)
Z11.3 screening if age <25
☐ Mycoplasma genitalium (MG)
☐ Trichomonas (TV)

APTIMA MULTITEST SWAB THROAT (ORANGE)
☐ Chlamydia/Gonorrhea (CT/GC)

APTIMA MULTITEST SWAB RECTAL (ORANGE)
☐ Chlamydia/Gonorrhea (CT/GC)

APTIMA MULTITEST SWAB VAGINAL (ORANGE) **(FEMALE ONLY)**
☐ Chlamydia/Gonorrhea (CT/GC)
Z11.3 screening if age <25
☐ Mycoplasma genitalium (MG)
☐ Trichomonas (TV)
☐ Bacterial Vaginosis (BV)
☐ Candida Vaginitis/Trichomonas (CV/TV)

APTIMA MULTITEST SWAB ANOGENITAL LESION (ORANGE) **(FEMALE/MALE)**
☐ Herpes simplex virus 1 & 2 (HSV)

HISTORY/CONDITIONS - CHECK (✓) ALL THAT APPLY

☐ Well woman exam **(Z01.419)**
☐ Previous Abnormal PAP/Biopsy **(Z01.42)**
☐ High Risk Sex – Heterosexual **(Z72.51)**
☐ High Risk Sex – Homosexual **(Z72.52)**
☐ High Risk Sex – Bisexual **(Z72.53)**
☐ Clinically apparent infection **(N76.89)**
☐ Abnormal bleeding **(N93.9)**
☐ Irregular menses **(N92.6)**
☐ Pregnancy _____ wks **(Z34.9__)**
☐ Postpartum _____ wks
☐ BC pills/Depo
☐ Itching/Burning/Discharge **(N76.0)**
☐ Estrogen
☐ HPV vaccinated
☐ Hysterectomy ☐ Partial ☐ Total
☐ IUD
☐ Suspected exposure to STI **(Z20.2)**
☐ Vulvar ulcer/lesion **(N76.6)**
☐ Vaginal ulcer **(N76.5)**
☐ Menopausal **(Z78.0)**
☐ Painful Sex **(N94.10)**
☐ Prior ablative/excisional therapy
☐ Clinical Cervicitis **(N72)**
☐ CT/GC screening **(Z11.3)**
(sexually active, 24 yrs and younger, and older women with increased risk)
☐ Herpes vulvovaginitis **(A60.04)**
☐ Penile ulcer **(N48.5)**
☐ Other _____

NON-GYN-CYTOLOGY

☐ Abdominal Fluid
☐ Breast Aspiration
☐ Fine Needle Aspiration
☐ Urine
☐ Pleural fluid

NON-GYN SOURCE
☐ Upper ☐ Left
☐ Lower ☐ Right
☐ Other source: _____

Clinical Dx or Tx History:

*MEDICARE PATIENTS

PLEASE COMPLETE, SIGN, AND DATE THE MEDICARE ABN ON THE BACK OF THIS FORM