UFHealth
PATHOLOGY LABORATORIES

Practice name _____

Address _____

Phone _____ Fax _____

GYNECOLOGICAL REQUISITION

PATIENT INFORMATION

Full Name (last, first, MI) _____
Sex: ■ Male ■ Female **Date of birth** (MM/DD/YYYY) _____
MRN# / Patient ID# _____

BILLING INFORMATION

■ **Bill to insurance** ■ **Bill to facility**

MUST include copies of the patient's demographics sheet and insurance ID card(s) front and back if not completing the requested information below.

Carrier name _____
Carrier phone _____
Carrier address _____
Policy # _____
Group plan # _____
Name of insured (if other than patient) _____
Date of birth (MM/DD/YYYY) **of insured** _____
Relationship of insured to patient _____
■ **SECONDARY INSURANCE EXISTS**
If checked, you MUST include secondary insurance information on a separate sheet

PROVIDER INFORMATION

Ordering physician _____
Ordering physician's NPI# _____
Duplicate report sent to _____
Duplicate report fax to _____

NOTICE TO ORDERING PHYSICIAN:
We respectfully ask that you authenticate your order for the pathologic examination of the accompanying specimen(s) by personally signing this requisition in the space provided or by initialing next to your printed name. If your signature (or initials) are not affixed hereto, you attest that you have caused the subject patient's medical record to include a specific reference (i.e., order) to your intent that the accompanying specimen(s) be examined by a pathologist and that you have personally signed (handwritten or electronic) said reference (i.e., order) in the subject patient's medical record.

Physician's Signature _____

Date (MM/DD/YYYY) _____

Name of person completing form _____

APTIMA TESTING

■ BV, CV/TV (Lab 3721)
■ CT/NG, BV, CV/TV (Lab 3720)
■ MG*, CT/NG, BV, CV/TV (Lab 3725) ***not intended for screening***
■ MG LAB1230800
■ CT/NG LAB1376
■ BV LAB1230900
■ CV/TV LAB1230600

PAP TEST (WITH OR WITHOUT HPV)

Method: ■ ThinPrep®
Pap site: ↓ *Cervical/endocervical unless checked below* ↓
■ Vagina ■ Other _____
■ Anal | **Indication for testing** _____
(HPV testing is not validated on anal Pap)
■ ThinPrep® ***with*** HPV* ■ ThinPrep® ***without*** HPV*
**HPV = High-risk screen with genotyping*

HPV/CT/NG TESTING

Specimen (Pap unless specified): ■ Swab ■ Urine
■ **Both** *Chlamydia trachomatis/Neisseria gonorrhoeae* nucleic acid testing (CT/NG) (Z11.3)
■ *Chlamydia trachomatis* only ■ *Neisseria gonorrhea* only
■ HPV w/reflex to genotype LAB5652

BIOPSY

■ Cervix Bx ■ Cervical cone ■ Cervical LEEP (anterior/posterior)
■ ECC ■ Endometrial Bx ■ Endometrial curettage
■ Vaginal Bx | **Location(s)** _____
■ Vulvar Bx | **Location(s)** _____
Urine: ■ Cytology ■ Cytology with UroVysion® (hematuria)
■ Other _____

CLINICAL HISTORY NARRATIVE/CLINICAL QUESTION*

**An Advance Beneficiary Notice of Noncoverage form must be completed and attached for all Medicare patients.*

Last Pap: _____ **LMP:** _____

■ Screening cervical Pap test (Z12.4)
■ Abn. appearance of cervix (N88.9)
■ Routine gynecological exam without abnormal findings (Z01.419)
■ Follow-up normal Pap with history of abnormal (Z01.42)
■ Screening vaginal Pap test (pt. without cervix) (Z12.72)
■ High-risk Pap test (onset sex < 16 years, multiple partners, STD, HIV, less than three negative Pap tests in the last seven years, DES exposure) (Z77.9)
■ Abnormal cervical Pap (R87.619)
■ Pregnancy (Z33.1)
■ Previous unsatisfactory Pap test (R87.615)
■ Malignant neoplasm cervix (C53.9)
■ Cervicitis (N72)
■ Vaginitis (N76.0)
■ Postmenopausal atrophic vaginitis (N95.2)
■ Dysfunctional uterine bleeding (N92.5)
■ Menometrorrhagia (N92.1)
■ Irregular menstrual cycle (N92.5)
■ Postmenopausal bleeding (N95.0)

Specify

Previous abnormal Pap? ■ No ■ Yes _____
Previous cervical Bx/LEEP? ■ No ■ Yes _____
Previous GYN malignancy? ■ No ■ Yes _____
Hormone therapy? ■ No ■ Yes _____
Prior radiation? ■ No ■ Yes _____
Contraception? ■ No ■ OCP ■ IUD ■ Depo ■ Bilateral, tubal ligation

ICD-10 code _____ **Specimen collection date** (MM/DD/YYYY) _____ **Time** _____

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