

**CYTO / TISSUE
Requisition**

2750 CLAY EDWARDS DRIVE, SUITE 420, NORTH KANSAS CITY, MO 64116 (816) 241-3338
(800) 933-6293
Fax (816) 241-6531

CLIENT NAME AND ADDRESS	PATIENT NAME (LAST) (FIRST) (MI)	SEX	DOB
	COLLECTION DATE	PATIENT NUMBER	PATIENT SSN

ORDERING PHYSICIAN	COPY REPORT TO:
	CC REPORT TO
	ADDRESS
	CITY STATE ZIP

RESPONSIBLE PARTY & INSURANCE (MAY ATTACH COPIES OF INSURANCE CARDS OR PATIENT DEMOGRAPHIC SHEET)	
BILL TO <input type="checkbox"/> PATIENT (SELF) <input type="checkbox"/> INSURANCE PT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER NAME OF INSURED (IF NOT SELF) INSURED'S SSN: ADDRESS CITY STATE ZIP PHONE NUMBER HOME WORK	<input type="checkbox"/> See Attached: Attach All Copies of Insurance

GYNECOLOGIC CYTOLOGY / MOLECULAR TESTS	
<u>GYN/CYTOLOGY SOURCE</u> LMP _____/_____/_____ <input type="checkbox"/> Cervical / Endocervical / Vaginal <input type="checkbox"/> Vaginal <input type="checkbox"/> Other CHECK ALL THAT APPLY: <input type="checkbox"/> Thin Prep Pap Test (ICD 10 _____) (Submit white top vial) <input type="checkbox"/> SurePath Pap Test (ICD 10: _____) (Submit blue top vial) HPV High Risk DNA Testing (Choose one): <input type="checkbox"/> SCREENING-Regardless of Pap Result (ICD 10: _____) <input type="checkbox"/> ASCUS REFLEX Testing Only <input type="checkbox"/> 16/18 Genotype if HPV Positive <input type="checkbox"/> Gonorrhea / Chlamydia by PCR (ICD 10: _____) <input type="checkbox"/> Chlamydia Only <input type="checkbox"/> Gonorrhea Only CTNG SOURCE: <input type="checkbox"/> From Pap vial <input type="checkbox"/> From Swab	FOR COMPLETE EVALUATION CHECK ALL THAT APPLY <input type="checkbox"/> Normal Exam <i>No prior abnormal PAP</i> <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Last Pap _____ Pregnant (Choose One) <input type="checkbox"/> First Pregnancy <input type="checkbox"/> Pregnancy Other than First <input type="checkbox"/> Post-Partum <input type="checkbox"/> Oral Contraceptives <input type="checkbox"/> IUD Implant ADDITIONAL COMMENTS: <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Post-Menopausal <input type="checkbox"/> Pelvic Radiation <input type="checkbox"/> No Pap w/in 7 years <input type="checkbox"/> Post-Menopausal Bleeding <input type="checkbox"/> Postcoital Bleeding <input type="checkbox"/> Abnormal Pap / BX w/in 3 years <i>(ASCUS, AGUS, or above)</i> <input type="checkbox"/> Gyn Malignancy: Hx / Rx <input type="checkbox"/> Abnormal Gyn Exam <i>(e.g. HPV, Cervical lesion)</i> <input type="checkbox"/> Previous Positive HPV <input type="checkbox"/> Smoker

PATHOLOGY				
SPECIMEN NUMBER	ANATOMIC SITE	CLINICAL DIAGNOSIS / ICD 9	MARGINS REQUESTED CHECK BOX IF DESIRED	SPECIMEN TYPE
A			<input type="checkbox"/>	Punch <input type="checkbox"/> Excision <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/>
B			<input type="checkbox"/>	Punch <input type="checkbox"/> Excision <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/>
C			<input type="checkbox"/>	Punch <input type="checkbox"/> Excision <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/>