



INSURANCE - COMPLETE OR ATTACH COPIES OF FACE SHEET OR CARD(S). (FRONT & BACK)

		PRIM	SEC	PRIMARY	
MEDICARE				NAME: _____	
CONSULTEC				ID: _____	
BCBS				GROUP #: _____	
CIGNA				INSURANCE CO. ADDRESS: _____	
LOVELACE					
CIMMARRON					
CIMMARRON SALUD				SUBSCRIBER'S EMPLOYER: _____	
ADMAR				SECONDARY	
HEALTHSMART				NAME: _____	
PATIENT				ID: _____	
ACCOUNT BILL				GROUP #: _____	
MOLINA				INSURANCE CO. ADDRESS: _____	
LOVELACE SALUD					
PRESBYTERIAN					
OTHER				SUBSCRIBER'S EMPLOYER: _____	

ORIGINAL TO PATHOLOGY · COPY FOR PATIENTS CHART

PATIENT INFORMATION

COLLECTION DATE: ____/____/____

S.S.#: _____

PRINT LAST NAME: _____ FIRST: _____ MI: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: _____ BIRTHDATE: _____ CHART #: _____

HOME PHONE #: _____ WORK PHONE #: _____

SPECIAL REQUESTS:

PLEASE COPY REPORT TO DR. _____

OTHER: _____

GYNECOLOGIC (PAP TESTING)

APPROPRIATE BOXES MUST BE CHECKED **ICD9 REQUIRED** **MUST ADD 4TH DIGIT**

DIAGNOSTIC PAP TEST: ICD9

NON-MEDICARE SCREENING PAP V76.2 V24. OTHER _____

MEDICARE LOW RISK SCREENING CODES (MEDICARE PAYS EVERY 2 YEARS)

CERVIX V76.2 **ABN FORM MUST BE ATTACHED**

VAGINA V76.47 (Hyst)

OTHER SITES V76.49

MEDICARE HIGH RISK SCREENING PAP (MEETS MEDICARE STANDARDS FOR MORE FREQUENT SCREENING THAN EVERY 2 YEARS) V15.89

MEDICAID: PREGNANCY OTHER V25. V23. V22. **MUST ADD 4TH DIGIT**

ANCILLARY TESTING FROM THE THIN PREP VIAL

THIN PREP PAP

PAP SMEAR HPV - HIGH RISK REFLEX IF ASCUS

DNA with PAP HPV - HIGH RISK PROFILE

CHLAMYDIA TRACHOMATIS/NEISSERIA GONORRHOEAE

HR(HPV and PAP for women > 30)

SOURCE: ENDOCERVIX ECTOCERVIX VAGINAL OTHER

PATIENT HISTORY

LMP: ____/____/____

PREGNANT POST MENOPAUSAL

POST PARTUM RADIATION

BCP HORMONES

INJ. CONTRACEPTIVE _____

IUD

HYSTERECTOMY OTHER _____

GYN CLINICAL FINDINGS

CERVICITIS VAGINITIS

ABNORMAL BLEEDING OTHER _____

PREVIOUS PAP DATE: ____/____/____

HISTORY OF ABNORMAL PAP

DATE: _____

DIAGNOSIS: _____

BIOPSY RESULT: _____

SURGICAL HISTORY

LASER/CRYO

COLPO

CONE/LEEP

COMMENT: _____

TISSUE PATHOLOGY

INDICATE SITE & SPECIMEN SOURCE.

1. _____

2. _____

3. _____

4. _____

5. _____

CLINICAL HISTORY: COMPLETE FOR TISSUE PATHOLOGY OR NON-GYN CYTOLOGY

PRE-OPERATIVE DIAGNOSIS:

POST OPERATIVE DIAGNOSIS:

NON-GYN CYTOLOGY

SOURCE: _____

FNA SPECIMENS

LEVEL OF CLINICAL SUSPICION

LOW HIGH

LEVEL OF RADIOLOGIC SUSPICION (MAMMOGRAM/SCAN)

LOW HIGH

CYTOWORKSHEET (FOR LAB USE ONLY)