



# GYN CYTOLOGY REQUISITION

Requesting Physician

**WESTCHESTER  
MEDICAL CENTER**

ADVANCED LABORATORY  
SERVICES

PATIENT DATA				INSURANCE BILLING INFORMATION		
Last Name:		First Name:		Patient Telephone Number (9 am to 5 pm) ( )		
Date of Birth:	Gender:	MRN:	Registration No:	Insured's Name (If different from patient):		Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Specimen collected by:		Patient Address:				
Date	Time			City	State:	Zip:
<b>ADVANCED BENEFICIARY NOTICE (ABN)</b>				Medicare ID Number:		<input type="checkbox"/> Regular <input type="checkbox"/> Railroad
An ABN (see reverse side of this requisition) must be signed when the doctor determines that the reason for the test requested does not meet local or national medical review policy requirements.				Medicaid ID Number (Including Suffix/Person No)		
ICD9 DX Codes:				Physician Signature:		
				Insurance Name/Plan/HMO		
				Policy ID Number:	Group/Book Number:	Category Number:

### ICD-9 Code (Check All that Apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 627.3 Atrophic Vaginitis             | <input type="checkbox"/> 621.0 Endometrial polyp              | <input type="checkbox"/> 627.1 Post menopausal bleeding        |
| <input type="checkbox"/> 795.01 Atypia, Cervix                | <input type="checkbox"/> 617.9 Endometriosis                  | <input type="checkbox"/> V22 Pregnancy                         |
| <input type="checkbox"/> 616.0 Cervicitis - Endocervicitis    | <input type="checkbox"/> 626.4 Irregular Menstrual cycle      | <input type="checkbox"/> 795.0 Previous abnormal cervical Pap  |
| <input type="checkbox"/> 078.11 Condyloma                     | <input type="checkbox"/> 635.90 Legal abortion                | <input type="checkbox"/> V72.3 Routine Pap-Gyn examination     |
| <input type="checkbox"/> 233.3 Carcinoma In-Situ, Cervix      | <input type="checkbox"/> 632 Missed abortion                  | <input type="checkbox"/> V76.2 Routine Pap (special screening) |
| <input type="checkbox"/> 626.8 Dysfunctional Uterine Bleeding | <input type="checkbox"/> 627.9 Menopausal disorder            | <input type="checkbox"/> 616.10 Vaginitis-Vulvovaginitis       |
| <input type="checkbox"/> 622.1 Dysplasia, Cervix              | <input type="checkbox"/> 627.0 Menorrhagia                    | <input type="checkbox"/> V15.89 High Risk Pap                  |
| <input type="checkbox"/> 622.7 Endocervical polyp             | <input type="checkbox"/> V69.2 Early onset of sexual activity | <input type="checkbox"/> V24.2 Postpartum                      |

PATIENT INFORMATION FOR SPECIMEN EVALUATION	CLINICAL HISTORY
<b>MUST CHOOSE DIAGNOSTIC PAP OR SCREENING PAP</b>	<b>Check all that apply for DIAGNOSTIC PAP:</b>
<input type="checkbox"/> <b>SCREENING PAP</b> Routine Normal Exam No Symptoms or Evidence of Disease. Note: *Medicare covers <u>Every 2 years</u> .  <input type="checkbox"/> <b>DIAGNOSTIC PAP</b> For Signs, Symptoms, Evidence of Disease. Note *Medicare Covers Every YEAR.	<input type="checkbox"/> No Pap test within 7 years <input type="checkbox"/> Previous abnormal Pap Test <input type="checkbox"/> Bleeding, post menopausal <input type="checkbox"/> Bleeding, Postcoital <input type="checkbox"/> Cervical Lesion <input type="checkbox"/> Endometriosis <input type="checkbox"/> Genital Herpes <input type="checkbox"/> HPV HX/Rx <input type="checkbox"/> Suspicious findings of female genital tract  <i>please specify</i>
<b>LMP:</b> ____/____/____  <b>Source:</b> <input type="checkbox"/> Cervical / Vaginal <input type="checkbox"/> Vaginal Only  <b>ThinPrep*</b> <input type="checkbox"/> Liquid-Based Pap Test	<input type="checkbox"/> HX of LSIL or higher Pap/Bx within 2 years <input type="checkbox"/> Neoplasm of female genital tract - Malignancy <input type="checkbox"/> ASCUS/AGUS Pap/Bx within 2 years <input type="checkbox"/> Inflammatory Disease of genital tract <input type="checkbox"/> Vaginitis
<b>Additional tests are available from the same vial when a Pap test is ordered depending upon specimen adequacy.</b>  <input type="checkbox"/> Liquid-Based Pap Test Reflex High Risk HPV <i>reflex HPV only from ASCUS interpretation</i> <input type="checkbox"/> Liquid-Based Pap & High Risk HPV, for ages 30 and over <input type="checkbox"/> HPV DNA typing* Regardless of diagnostic outcome *Please note: Patient may be responsible for payment  <input type="checkbox"/> Chlamydia trachomatis DNA/SDA <input type="checkbox"/> Neisseria gonorrhoea DNA/SDA <input type="checkbox"/> Chlamydia / N gonorrhoea DNA/SDA	<b>CURRENT PATIENT STATUS:</b> <input type="checkbox"/> Oral Contraceptive <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Pregnant <input type="checkbox"/> Postpartum <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Pelvic Radiation
<b>Additional History / Clinical Comments:</b>	

Send Copies of Test Results to: Physician (Full Name, Phone #, Fax #)