

CYTOLOGY (GYN) REQUISITION

YPMG

**YOSEMITE PATHOLOGY
MEDICAL GROUP, INC.**
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Modesto, CA 95355
(209) 577-1200
In California 1-888-644-YPMG

Accession Number

(YPMG LAB USE ONLY)

Client Name and Address

NOTE: CA TITLE 17 (SEC. 1050) REQUIRES THE PHYSICIAN TO PROVIDE PATIENT'S DOB, SOURCE OF SPECIMEN, LMP, HISTORY, THERAPY AND SLIDE / VIAL LABELED APPROPRIATELY - TWO (2) IDENTIFIERS.

Type of Billing: Patient Insurance Medicare Medi-Cal

Date Collected	Patient Name (Last) _____ (First) _____ (M.I.) _____	Birth Date (Required)	Sex
Street Address/Apt.# _____		City _____	State _____ Zip _____
Social Security No. (Required)	MRN# _____	Responsible Party Telephone _____	Requesting Physician _____

PLEASE ATTACH FRONT AND BACK COPY OF INSURANCE CARD

PAP <input type="checkbox"/> CONVENTIONAL - Slide <input type="checkbox"/> LIQUID BASED - Vial	NON-MEDICARE PATIENTS: <input type="checkbox"/> Routine Screening <input type="checkbox"/> High Risk Screening <input type="checkbox"/> Diagnostic - ICD-10 Code _____	MEDICARE PATIENTS: (See reverse side for ABN) <input type="checkbox"/> Routine Screening V76.2 <input type="checkbox"/> High Risk Screening V15.89 <input type="checkbox"/> Diagnostic - ICD-10 Code _____ <input type="checkbox"/> Non-Covered Services V76.2 (Signed ABN Required)
COLLECTION METHOD: <input type="checkbox"/> ThinPrep <input type="checkbox"/> SurePath		

HPV - High Risk Assay <input type="checkbox"/> Reflex from Abnormal Pap <input type="checkbox"/> Pap with HPV* <input type="checkbox"/> HPV Only <small>*Adjunctive High Risk HPV for women over 30</small>	HPV - 16/18 Genotype <input type="checkbox"/> HPV High Risk with Reflex to HPV 16/18 <small>(Testing includes HPV High Risk 16/18 when indicated)</small> <input type="checkbox"/> HPV 16/18 Only <small>(Used for Previous HPV High Risk positive)</small>	Chlamydia / Gonorrhea <input type="checkbox"/> HC2 CT/GC DNA Test <small>(Liquid Based-Indicate Vial)</small> <input type="checkbox"/> HC2 CT/GC DNA Test <small>(Cervical Sampler)</small>	Microbial Identification <small>(Affirm VPIII Sample collection swab)</small> <input type="checkbox"/> Gardnerella vaginalis <input type="checkbox"/> Trichomonas vaginalis <input type="checkbox"/> Candida species
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Gynecologic Source: REQUIRED Vaginal Endocervical Cervical Cuff

CLINICAL HISTORY: THIS INFORMATION IS ESSENTIAL FOR ACCURATE INTERPRETATION

AGE _____ LMP _____ CLINICAL DIAGNOSIS _____ **ICD-10 CODE** _____

<input type="checkbox"/> PREGNANT	<input type="checkbox"/> POSTPARTUM	<input type="checkbox"/> HYSTERECTOMY	<input type="checkbox"/> CRYOSURGERY	<input type="checkbox"/> POST ABORTION	PREVIOUS SMEARS
<input type="checkbox"/> POSTMENOPAUSAL	<input type="checkbox"/> total <input type="checkbox"/> subtotal	<input type="checkbox"/> CERVICAL BIOPSY	<input type="checkbox"/> HX OF MALIGNANCY	DATE _____	
<input type="checkbox"/> HORMONE RX	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> ABNORMAL COLOSCOPY	<input type="checkbox"/> HX OF GYN CANCER	INTERPRETATION _____	
<input type="checkbox"/> ORAL CONTRACEPTIVES	<input type="checkbox"/> RADIATION RX	<input type="checkbox"/> CLINICAL HIGH RISK	<input type="checkbox"/> HX OF GYN SURG	WHERE _____	
<input type="checkbox"/> INTRAUTERINE DEVICE	<input type="checkbox"/> DES EXPOSURE	<input type="checkbox"/> ABNORMAL BLEEDING		PREVIOUS LAST NAME _____	
				(if changed in last 5 years)	

FOR LAB USE ONLY: TECH

ADEQUACY: _____
 GEN CATEGORY: _____
 INTERPRETATION: _____
 COMMENT: _____

QA / ABNORMAL REVIEW

Adequacy: _____
 Gen Category: _____
 Interpretation: _____
 ___ Agree with Diagnosis
 ___ Disagree, Category A
 ___ Disagree, Category B
 Comments: _____
 Reviewer: _____ Date: _____