Laboratory Services
Cytopathology Gynecologic Test Requisition

Memorial Hospital
1400 East Boulder
Colorado Springs, CO 80909
719-365-5260

Cytology Office
719-364-3200

BILL TO:
☐ My Account

☐ Patient's Insurance

Attach copy of patient's demographic and insurance information. If not provided, your office will be billed by default.

Memorial Central CLIA # 06D0663026 Memorial North CLIA # 06D1065861

PATIENT INFORMATION		
Last Name	First Name, Middle Initial	Birthdate
Date of Service	**ICD 10** (Required)	
ORDERING PROVIDER INFORMATION		
Practice Name: Ordering Provider:	Address:	Phone: Fax:

Specimen container must exhibit two patient identifiers.

SPECIMEN SOURCE
☐ Cervical/Endocervical ☐ Vaginal ☐ Other, specify:

TEST(S) REQUESTED	**CLINICAL INFORMATION**	**RISK FACTORS**
☐ ThinPrep Pap Test ☐ Molecular tests only No Pap	LMP *Mo. Day Yr* _____/_____/_____	☐ Previous Abnormal Pap*(date and result)* *Mo. Day Yr* _____/_____/_____
HIGH RISK HPV mRNA TESTING ☐ Reflex HPV if ASCUS ☐ Co-Testing women age 30 and older ☐ HPV on any diagnosis **HPV GENOTYPING** ☐ 16, 18/45 if High Risk Positive	☐ Pregnant ☐ Postpartum ☐ Peri/Postmenopausal ☐ Hysterectomy cervix absent ☐ Hysterectomy cervix present ☐ IUD ☐ Hormone Therapy	☐ SIL within last 5 years ☐ Positive HPV Test within last 3 years ☐ No Pap test within last 5 years ☐ Previous GYN Malignancy (specify)
ADDITIONAL MOLECULAR TESTING ☐ Chlamydia RNA ☐ Gonorrhea RNA ☐ Other, specify:	Additional Pertinent Information:	

Form 44525