University Hospitals
Elyria Medical Center

LABORATORY ORDER
Cytology with Microbiology

Place LIS Label Here (Lab Use Only)

University Hospitals Elyria Medical Center ● 630 East River St. ● Elyria, OH 44035 ● Lab 440/329-7531 ● Lab Fax 440/329-7685
University Hospitals Amherst Health Center ● 254 Cleveland Avenue ● Amherst, OH 44001 ● Lab 440/988-6176 ● Lab Fax 440/988-6017
University Hospitals Avon Health Center ● 1997 Healthway Dr. ● Avon, OH 44011● Lab 440/988-6940●Fax 440/988-6945

Patients Name	(First)	(MI)	Sex	Date of Birth	Social Security

Patient Address (street) (City) (St) Area code/Phone

Parent or Guardian (if minor)

ICD-10 Codes(s) with full diagnosis description.

Standing Order: Indicate frequency, Starting Date and Ending Date of Order. Maximum length 1
Frequency: Start Date: End Date:

Type of Exam:
☐ Screening ☐ Diagnosis ☐ Preoperative

PAT Scheduled
Date: _____ Time:

Physician's Signature (Required) Date of Order

Bill Services To:
☐ Physician/Client ☐ Patient ☐ Insurance*Attach copy of insurance card front & back.* ☐ Other

Ordering Physician Name
(First and Last name please print)

NPI:
Phone:
Fax:

To expedite please provide a copy of the insurance card front and back. If available include a Photo ID.
Please have lab test done as follows:
[ ] Now
[ ] Return _____ (Date)
[ ] Call Results
[ ] Fax Results

Orders must include:
Physician' s Signature
Patient demographics
Patient's insurance
Codeable diagnosis

All Samples must be labeled:
Patient's full legal name
Date of birth
Collection date and time
Collector's Initials

GYN-CYTOLOGY (GYNSP)

Clinical Information:

Specimen Type: Liquid based __ Conventional __
LMP: Date:___/___/___
Pregnant: Yes__ Postpartum: Yes__
IUD: Yes __ Hormone therapy: Yes__
Birth Control: Yes__ Hormonal: Yes__
Previous surgery: Yes __ Date: ___/___/___
Type:
Menopausal: Yes__ Hysterectomy: Yes__
Supra Cervical: Yes__ Chemotherapy: Yes__
Radiation: Yes__ DES exposure: Yes__
Previous abnormal PAP: Yes__ Date:
Post-menopausal bleeding: Yes__
CVX Stenosis: Yes__
Other clinical remarks:

Test:

[ ] Pap Only **(Age 21-24 pap only no HPV)**
[ ] Pap **w/rfx** to HPV **(Age 25-29 and Medicare for ASC-US only)**
[ ] Pap **w/rfx** to HPV and Genotypes 16,18,45 *ABN*

[ ] Pap **with** HPV *ABN*
[ ] Pap **with** HPV **w/rfx to** Genotypes 16, 18, 45 *ABN*
(Age 30-64 all diagnosis except ASC-H,HSIL and Carcinoma, and follow-up of abnormal.)

[ ] HPV only (HPV)
[ ] HPV (HPV) **w/rfx** to Genotypes 16, 18, 45
Note: HPV Reflex/Genotyping testing performed at an additional charge. Results may be issued as an addendum to the pap test.

Source:

[ ] Endocervical [ ] Cervical
[ ] Lateral Vaginal [ ] Vaginal DES Ex
[ ] Vaginal with disclaimer

NON-GYN CYTOLOGY (MEDSP)

Source of Specimen:

[ ] Breast: __Left __Right
[ ] Nipple: __Left __Right
[ ] Ovary: __ Left __Right
[ ] Pelvic fluid: __Left __Right
[ ] Other with disclaimer

MICROBIOLOGY

GYN Additional Thin Prep Vial Testing

[ ] GC & Chlamydia (GCCHA)
[ ] Trichomonas (TRICA)
Note: GC, Chlamydia, Trichomonas, testing performed at an additional charge. Results will be issued on a separate report.

Additional Micro collections

[ ] GC & Chlamydia Amplified (GCCHA)
___Urine ___Swab Endocervical
[ ] Trichomonas (TRICA)
___Urine ___Swab Endocervical
[ ] Vaginal Pathogens DNA (VAG)
[ ] Culture, Genital (GENLO)
[ ] Culture, Group B Strep (GBSCR)
[ ] HSV PCR (Skin/Mucosa) (HSVSS) *
Source: Site:
[ ] Viral (Non-Respiratory) Culture (VCULT) *
Source: Site:
[ ] Ureaplasma/Mycoplasma Culture (CUUPL) *
Source:

ABN =this test may require an ABN form. Medicare will cover a routine pap once every three years (once every year for high risk patients). If you are ordering a pap smear for a Medicare Patient who exceeds frequency please attach a completed **ABN** form. Testing will be subject to pathology professional billing, Pathologist can bill the patient or the patient's insurance additional billing may apply if special studies are indicated. * Collect in M4/UTM media, place in a separate transport bag.