PAP SMEAR REQUISITION

Department of Pathology
325 Maine Street Lawrence, Kansas 66044
Telephone: 785-505-6170 Fax: 785-505-5224

PATIENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH / /	DATE COLLECTED / /

SOCIAL SECURITY NUMBER — —	PREVIOUS SURNAME/MAIDEN NAME	HOME PHONE ( )	WORK PHONE ( )

ADDRESS	CITY	STATE	ZIP

INSURANCE / BILLING INFORMATION MUST BE COMPLETED or attach front and back copies of insurance card.

BILL TO: ____DOCTOR / CLINIC ____PATIENT

____MEDICARE / MEDICAID* ____INSURANCE*

Please Note Medicare's guidelines when ordering tests – "screening" tests are generally not covered. Please submit a valid Advanced Beneficiary Notice when appropriate.

SUBSCRIBER NAME	EMPLOYER	PRIMARY INSURANCE CO	SECONDARY INSURANCE CO
SUBSCRIBER ADDRESS	EMPLOYER ADDRESS	SUBSCRIBER ID NUMBER	SUBSCRIBER ID NUMBER
CITY / STATE / ZIP	CITY / STATE / ZIP	GROUP NUMBER	GROUP NUMBER

PHYSICIAN INFORMATION

DOCTOR / PRACTITIONER SIGNATURE DATE	Please Provide Reason for **Pap Smear Exam** Below*

ORDERING PHYSICIAN (PLEASE PRINT)	COPIES TO:	FOR LAB USE ONLY **P-**

*One of the Following MUST BE Checked

___**Non-Medicare Patient** (Circle one) **Routine/Annual Pap** **Repeat/Follow-Up** (Include Diagnosis/reason below) **Other** (explain below)

___**Medicare Patient – Screening Pap**, routine (reimbursable once every 2 years) ***ABN REQUIRED (must accompany req)***

___**Medicare Patient – Screening Pap**, high risk of cervical cancer and physician recommends more frequent screening based on medical history (reimbursable once every year) ***ABN REQUIRED (must accompany req)***

___**Medicare Patient - Diagnostic Pap**, history of abnormal pap smear or signs and symptoms of medical necessity (**Diagnosis Required**, See below)

Signs and Symptoms / Diagnosis_____

(CHOOSE ONE)

Testing: _____ThinPrep Pap With HR HPV _____ ThinPrep Pap w/HR HPV Testing **IF ASCUS** _____HR HPV Testing Only _____ThinPrep Pap Only

Anatomic Site(s): _____Cervix _____ Endocervix _____ Vagina Other:_____

Clinical History:

Date of Last Menstrual Period _____ ___ Pregnant ___Post-Partum ___Post-Menopausal ___Peri-Menopausal

(CIRCLE ALL THAT APPLY)

History of Abnormality: ASCUS LGSIL HGSIL +HR HPV DNA Herpes Other STD Abn Exam _____

Treatment/Gyn Surgery: Hyst(total) Hyst(supracervical) Oophorectomy Colpo/No biopsy Colpo/with biopsy Laser Cryo LEEP/Cone

Contraceptive/Hormonal Therapy: Hormonal Contraceptives HRT Estrogen Only Tamoxifen _____

Abnormal Bleeding: Irregular Spotting Heavy Frequent Breakthrough _____

Cancer History: Cervical Endometrial Ovarian Breast Colon Lymphoma Other:_____

Additional Information: _____