UNITED PATHOLOGY SERVICES

personalized service
uncompromised quality

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Patient Information		Provider Information	
Name:			
Address:			
City, State, Zip Code:		**Clinician Signature REQUIRED:**	Date
Phone Number:	**Social Security Number:**		
Date Of Birth:	Gender: ☐ Female ☐ Male ☐ Other	Copy To:	Fax:
Specimen Collection Date:	**Diagnosis/ICD-10 Codes REQUIRED:**		

Billing/Insurance (or attach copy of insurance card, front and back)					
Bill:	**Insurance:**				
☐ Insurance	Name/Relationship to Insured:				
☐ Self-Pay	Company Name:			Employer Name:	
☐ Medicare	Address:			Policy/Group #	Member ID #
☐ Medicaid	City:	State:	Zip Code:	Medicare #	Medicaid #

Clinical Information	GYN Cytology	Surgical Pathology/Histology
Clinical History	**LMP ____ /____ /____**	**Clinical History:**
☐ Routine Pap	**Specimen Source:**	_____
☐ Pregnant	☐ Vaginal ☐ Cervical/Endocervical	_____
☐ Post-Partum	☐ Other _____	_____
☐ Postmenopausal	**Pap Test:**	_____
☐ Estrogen Replacement Therapy	☐ Thin Prep	_____
☐ Hormonal Birth Control/BCP	**HPV (High Risk HPV Only):**	
☐ IUD	☐ HPV Reflex for ASCUS or AGCUS	**Tissue Submitted: List Specimen Source**
☐ Total Hysterectomy	☐ HPV Reflex for ASCUS or LSIL	1. _____
☐ Supracervical Hysterectomy	☐ HPV for any diagnosis	2. _____
High Risk Data	☐ No HPV	3. _____
☐ Previous GYN Malignancy	☐ HPV Only (No Pap Test)	4. _____
☐ History of HPV or Dysplasia	**Other:**	5. _____
☐ No Pap in Past 5 Years	☐ Chlamydia ☐ Gonorrhea	6. _____
☐ History of STD	**Non-GYN Cytology**	7. _____
☐ Abnormal GYN Exam	☐ FNA site: _____	8. _____
☐ High Risk Sexual Behavior	# of slides: Fixed _____ Air Dried _____	
☐ DES exposure	☐ Urine	
	☐ Cyst aspirate site: _____	

White - Lab Yellow - Client