avero DIAGNOSTICS
Pathology, Molecular Diagnostics, Research

Client Services: 1-866-987-7284

GYN PATHOLOGY REQUISITION

123456789

Specimen Collection Date:_____Time: _____

PATIENT INFORMATION

Patient Name (Last, First, MI) | Chart#

SSN | DOB | Sex M / F

Address

City | State | ZIP | Phone

Patient Insurance Information - Please provide copy of insurance card(s)

Primary Insurance ☐Medicare ☐Ins. ☐Patient ☐Client Bill

☐ Self ☐ Spouse ☐ Child

Company

Policy / ID Number

Group Number

Secondary Insurance ☐ Medicare ☐Ins.

☐ Self ☐ Spouse ☐ Child

Company

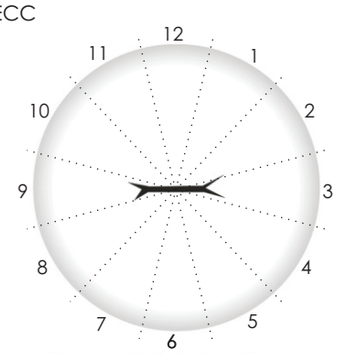
Policy / ID Number

Group Number

PHYSICIAN INFORMATION

GYNECOLOGIC HISTOLOGY (DIAGRAM)

☐ A. Endocervical Curretting -ECC
☐ B. Endometrial Biopsy - EMB
☐ C. Cervical Biopsy
☐ D. Cervical Cone
☐ E. Labial Biopsy
☐ F. LEEP - Anterior
☐ G. LEEP - Posterior
☐ H. Perineum Biopsy
☐ I. Vaginal Biopsy
☐ J. Vulvar Biopsy
☐ K. Colposcopy
☐ Other_____



Cervical Diagram with Patient in Lithotomy Position

Please Note the Biopsy Site

DIAGNOSTIC INFORMATION (ICD-9) Check all that apply

	V15.89 Other Specified Personal History presenting hazard to health
	V22.2 Pregnancy
	V76.2 Routine Cervical Pap Smear
	V76.47 Screen for Malignant neoplasm, vagina
	180.9 Malignant Neoplasm Cervix
	616.0 Cervicitis
	616.10 Vaginitis
	622.10 Dysplasia Cervix
	626.8 Abnormal Bleeding
	627.1 Postmenopausal Bleeding
	627.3 Atrophic Vaginitis
	795.00 Abnormal Cervical Pap Smear
	795.08 Previously Unsatis. Pap Smear
	OTHER

CLINICAL INFORMATION (Check all that apply)

☐ Abnl. Appearing Cervix
☐ Postpartum
☐ History of Adeno Ca
☐ History Invasive CA
☐ Prior Conization
☐ Colposcopy w/ Biopsy
☐ Prior Cryosurgery
☐ Prior LEEP/Laser Surgery
☐ History of Radiation

☐ BC / OCP
☐ Depo Provera
☐ IUD
☐ Pregnant
☐ Hormone Therapy
☐ Prior Hysterectomy
☐ Post Menopausal
☐ Abnormal Bleeding

☐ History of Abnormal Pap - Specify_____

☐ Other _____

GYN CYTOLOGY

SPECIMEN SOURCE
☐ Cervix/Endocervix ☐ Vagina ☐ Breast

TEST SUBMITTED
☐ Pap Test - Liquid Based ☐ Thin Prep™ ☐ SurePath™
☐ DNA Pap (High Risk HPV & Pap)*recommended in women>30Yrs ThinPrep™ or SurePath™
☐ Medicare Screening Pap Smear (Must check 1 below)
- ☐ Low Risk, Cervical - Every 2 yrs
  Dx: V76.2 Routine Cervical Pap Smear
- ☐ Low Risk, Vagina - Every 2 yrs
  Dx: V76.49 screen for malignant neoplasm, vagina
- ☐ Low Risk, Routine gynecological examination - Every 2 yrs
  Dx: V72.31 Routine gynecological examination(Eff. July 1, 2005)
- ☐ High Risk - Medical History - 1 per year
  Dx: V15.89 Other specified personal history presenting hazards to health

Medicare patients with screening Paps must sign the ABN located on the back

☐ HALO™ Breast Pap Test

DATE LMP _____ / _____ / _____
month Day Year

MOLECULAR

☐ HPV (High Risk)Reflex if ASC-US
☐ HPV (High Risk) Only (No Pap)
☐ HPV Type 16 & 18 - Reflex if High Risk Positive
☐ *Gonorrhea / Chlamydia*
☐ Group B *Streptococcus*
☐ Herpes 1 & 2
☐ Vaginosis Panel (*Trichomonas, Candida, Gardnerella)*
☐ Cystic Fibrosis Panel
☐ Other _____

PHYSICIAN INSTRUCTIONS

1. Complete the requisition with all requested information.
2. Clearly print the patient name on the label (do not write on the bar code)
3. Place one label on each specimen container(not the lid)
4. Medicare patients with a screening Pap smear must sign the ABN located on the back of this requisition.

GYN000000 ThinPrep™ Pap ☐ SurePath™ Pap ☐ Name	GYN000000 Cervical Cone Name	GYN000000 Anterior Leep Name	GYN000000 HALO Breast Pap Test - L Name
GYN000000 HPV Only Name	GYN000000 Cervical Biopsy Name	GYN000000 Posterior Leep Name	GYN000000 HALO Breast Pap Test - R Name
GYN000000 Group B Strep Name	GYN000000 Colpo Biopsy Name	GYN000000 Perineum Name	GYN000000 _____O'Clock Cervical Biopsy Name
GYN000000 Vaginosis Panel Name	GYN000000 ECC Name	GYN000000 Vaginal Biopsy Name	GYN000000 _____O'Clock Cervical Biopsy Name
GYN000000 Herpes 1 & 2 Name	GYN000000 EMB Name	GYN000000 Vulvar Biopsy Name	GYN000000 _____ Name

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