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PATHOLOGY SERVICES OF SPRINGFIELD

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Laboratory use only

GYN PATHOLOGY REQUISITION

Date:

PATIENT INFORMATION:

Last Name _____ First Name _____ Middle Name _____ Social Security No._____

Address _____ Physician Name _____

City _____ State _____ Zip Code _____ Medicare/Medicaid Authorized Physician /Practitioner signature (REQUIRED)

Age _____ Sex _____ Date of Birth _____ Physician Address _____

SOURCE OF TISSUE:

PERTINENT CLINICAL INFORMATION:

LMP _____ Previous PAP smear results (check appropriate box)

- ☐ Normal
- ☐ ASCUS
- ☐ AGUS
- ☐ ASCH
- ☐ LSIL
- ☐ HSIL
- ☐ Other (specify)

Date of last PAP smear _____

Is patient receiving hormone therapy (including BCPs) ☐ Yes ☐ No

If so, what medication? _____

Reason _____

BILLING INFORMATION:

Medicaid # _____ Medicare # _____

OTHER INSURANCE:

Name _____ Policy # _____

Address _____ Group # _____

Policy Holder's Name _____ Employer _____

IF THIS FORM IS NOT FULLY COMPLETED, THE PROCESSING OF THIS SPECIMEN WILL BE DELAYED.

SPECIMEN TO BE PLACED IN 10% FORMALIN AS SOON AS OBTAINED