BASSETT HEALTHCARE NETWORK
The Mary Imogene Bassett Hospital
One Atwell Road
Cooperstown, New York 13326-1394
(607) 547-3700

Ordering Physician # ___________

Attending Physician # ___________

DATE OF REQUEST: ______ VISIT NUMBER: ______

MR #: ______ LOCATION: ______

Name Last: ______ First: ______

DATE OF BIRTH: ______

☐ **RUSH** Contact Pathologist | ☐ **ROUTINE**

CYTOLOGY NO.

SURGICAL NO.

19

CYTOLOGY REQUEST FORM

#2215 12/02;12/03;9/05;5/06; 12/06;3/08;2/09;9/10,5/15;9/15;10/19;9/19/23 (f:\lab\cytol\.doc)

SPECIMEN		
COLLECTED BY:	TIME:	DATE:

PLEASE COMPLETE FOR CYTOLOGY REQUESTS

Pap Test (LAB5)

Test Order (check 1 or more boxes)
- ☐ Thinprep pap test
- ☐ HPV regardless of results
- ☐ If pap is normal and patient >30, HPV test performed. If HPV positive - subtyping will be performed.
- ☐ HPV if ASCUS or LGSIL (any age). No subtyping will be performed.
- ☐ If patient is >30 years and pap is normal/ASCUS/LGSIL , HPV test performed.
  If pap is normal and HPV positive – subtyping will be performed.

Molecular Testing from ThinPrep
Order individual tests below only if not ordering panel
- ☐ STI panel (rRNA amplification)
  - ☐ N. gonorrhoeae
  - ☐ Chlamydia trachomatis
  - ☐ Trichomonas vaginalis

Specimen Source
- ☐ Endocervical
- ☐ Endocervical
- ☐ Vaginal

Indications
- ☐ Routine Screening
- ☐ High Risk Screening
- ☐ Diagnostic pap

Patient signed ABN/waiver ☐ Yes ☐ No

Menstrual History
LMP ___________
- ☐ Pregnant ________ wks
- ☐ Post Partum ________ wks
- ☐ Post Menopausal ________ yrs
- ☐ Hysterectomy

Hormonal History
- ☐ Hormone Replacement Therapy
- ☐ Depo Provera
- ☐ BCP
- ☐ IUD
- ☐ DES exposure

Prior Treatment
Last Pap Dated ____________ ☐ Normal ☐ Abnormal pap
Treatment:
☐ Cryo/Lazer ☐ Conization ☐ Colposcopy/Biopsy Results ____________________

Non-gynecological (LAB13)

- ☐ CSF
- ☐ Sputum
- ☐ Ascites
- ☐ Pleural Fluid
- ☐ Tzanck
- ☐ Breast Discharge
- ☐ Voided Urine
- ☐ Instrumented Urine
- ☐ Post Cysto Urine
- ☐ Bronch, Wash ☐ L ☐ R
- ☐ Bronch, Brush ☐ L ☐ R
- ☐ Needle Aspiration (Specify Source) ____________________
- ☐ Gastrointestinal (Specify Source) ____________________
- ☐ Other (Specify Source) ____________________

HX OF MALIGNANCY: ☐ YES ☐ NO

WHEN: ____________________

TYPE/PRIMARY: ____________________

THERAPY: ☐ RADIATION ☐ CHEMO ☐ SURGERY — Specify Below

SMOKER: ☐ YES ☐ NO

DETAIL: ____________________

PATIENT COMPLAINTS/CLINICAL HISTORY

____

____

Please sign and indicate ICD10 Code:

Signature:

ICD10 Code

REQUISITIONS Lab