PATHOLOGY ASSOCIATES

305 Park Creek Drive
Clovis, CA 93611
(559) 326-2800

Paul H. Atmajian, M.D.
Stephen M. Avalos, M.D.
Baorong Chen, M.D.
Reuben S. Doggett, M.D.
Robert M. Futoran, M.D.
Clarke T. Harding, M.D.
Gordon D. Honda, M.D.
William C. Pitts, M.D.
John S. Pollard, M.D.
David L. Slater, M.D.
Michael Weilert, M.D.
Artur Zembowicz, M.D., PhD.

Sierra Pathology Laboratory Inc. CLIA # 05D0928145

OFFICE / FACILITY

PATIENT'S LAST NAME | FIRST NAME

DATE COLLECTED | TIME COLLECTED | DOB | SEX

SOCIAL SECURITY # --- --- | PHONE #

ADDRESS

CITY, ZIP | PATIENT ID #

☐ COPY OF INSURANCE CARD ATTACHED (FRONT AND BACK) ☐ BILL PATIENT

PLEASE HAVE MEDICARE PATIENTS READ AND SIGN ADVANCED BENEFICIARY NOTICE (ABN) ON THE BACK OF FORM

SEND DUPLICATE REPORT TO:

GYN CYTOLOGY REQUEST

AGE | **LMP** | **DIAGNOSIS:** | **ICD-9 CODE(S) OR S-CODE(S):**

- ☐ **LIQUID BASED PAP (SurePath© or ThinPrep© Pap Test™)**
- ☐ **LIQUID BASED PAP WITH REFLEX TO HPV IF ASCUS / AGUS**
- ☐ **LIQUID BASED PAP WITH REFLEX TO HPV IF ASCUS OR ABOVE**
- ☐ **LIQUID BASED PAP AND HPV (PERFORM HPV TESTING FOR ANY DIAGNOSIS)**
- ☐ **CONVENTIONAL PAP**
- ☐ **GC AND CHLAMYDIA**

- ☐ CERVICAL COLLECTION
- ☐ VAGINAL ONLY COLLECTION (PATIENT WITH TOTAL HYSTERECTOMY)

- ☐ SCREENING PAP: ROUTINE
- ☐ SCREENING PAP: HIGH RISK OF CERVICAL CANCER AND PHYSICIAN RECOMMENDS MORE FREQUENT SCREENING BASED ON MEDICAL HISTORY
- ☐ PAP SMEAR: HISTORY OF ABNORMALITY OR SIGNS OR SYMPTOMS OF MEDICAL NECESSITY

- ☐ POST MENOPAUSAL
- ☐ PREGNANT
- ☐ POST PARTUM
- ☐ HORMONE RX
- ☐ ORAL CONTRACEPTIVES

HYSTERECTOMY
- ☐ TOTAL
- ☐ SUPRACERVICAL (CERVICAL STUMP REMAINING)

- ☐ INTRAUTERINE DEVICE
- ☐ CHEMOTHERAPY
- ☐ RADIATION RX
- ☐ DES EXPOSURE
- ☐ CRYOSURGERY

- ☐ CERVICAL BIOPSY
- ☐ ABNORMAL COLPOSCOPY
- ☐ CLINICAL HIGH RISK
- ☐ ABNORMAL BLEEDING

PREVIOUS SMEAR(S)
DATE _____
DIAGNOSIS _____
LAB _____

NON-GYN CYTOLOGY REQUEST

- ☐ **BODY FLUID (SOURCE)** _____
- ☐ **NEEDLE ASPIRATION (SITE)** _____
- ☐ **BRUSHING / WASHING (SOURCE)** _____
- ☐ **SPUTUM**
- ☐ **URINE**
- ☐ **OTHER** (SOURCE) _____

TISSUE PATHOLOGY REQUEST

DIAGNOSIS: | **ICD-9 CODE(S):**

CLINICAL DATA:

BREAST TISSUE; DATE & TIME PLACED IN 10% BUFFERED FORMALIN: _____/_____/_____ _____:_____

SPECIMEN SITE(S): **# SPECIMENS** ☐ **# CONTAINERS** ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PATHOLOGY REQUISITION