Add-On Test Request Form

Please fax as soon as possible to:

Attention Cytology **Fax# 785.537.3592**

FOR CLIENT USE

Patient Name:________________________________ **Pap Smear #**______________________

Test(s) to be added:

___ HPV PCR (16, 18, All Others*) ICD-10 or Reason for Add-On: __________
*Includes 31,33,35,39,45,51,52,56,58,59,66,68

___ CT (Chlamydia) ICD-10 or Reason for Add-On: __________

___ NG (Gonorrhea) ICD-10 or Reason for Add-On: __________

___ CT + NG (Chlamydia + Gonorrhea) ICD-10 or Reason for Add-On: __________

Ordering Provider: __________________________ **Client Contact**:_________________

Federal Regulations require that we maintain on-file, written authorization for all Laboratory Testing. Accordingly, we are asking that the ordering provider (or their authorized representative) sign a copy of this request and promptly return it to the Cytology Department.

Authorized Signature:_________________________________ **Date**:___________________