



CLIA # 17D0449919
 1133 College Ave., Bldg B, Ste 131
 Manhattan, KS 66502
 Ph.: (785) 539-5363 • Fax: (785) 537-3592
 1-800-876-5522
 www.petersonlab.com

FEDERAL LAW REQUIRES REJECTION OF ALL SPECIMENS WITH INCOMPLETE INFORMATION

LAB # _____

PATIENT (Last Name) _____ (First) _____

DATE OF BIRTH	DATE COLLECTED	SOCIAL SECURITY NUMBER	MEDICAL RECORD #
PHYSICIAN	PATIENT TELEPHONE NO.		
RESPONSIBLE PARTY		RELATIONSHIP	
ADDRESS		PHONE #	
CITY		STATE	ZIP

PLEASE CHECK APPROPRIATE BOX FOR PRIMARY INSURANCE

PATIENT ACCOUNT

BC/BS ID # _____ GR. # _____

MEDICARE ID # _____

MEDICAID ID # _____ TYPE _____

OTHER INS. NAME _____ ID. # _____

INSURANCE ADDRESS _____ GR. # _____

SUBSCRIBER NAME _____

BENEFICIARY AGREEMENT: PATIENT WAIVER (Advance Beneficiary Notice): Please **complete** and have the **medicare patient sign** a PLS ABN form and attach it to this requisition if the patient has an **unpayable diagnosis** or if the patient has had a **screening pap** within the last **2 years**.

PLEASE INCLUDE COPY OF DEMOGRAPHIC SHEET and INSURANCE CARDS - Front & Back

PAP Testing

(choose one)

ThinPrep Liquid Based with Image (88175) Conventional Pap Test (88164) _____ # of slides submitted

ThinPrep Liquid Based without Image (88142) **Concurrent Biopsy**

HPV Testing (87624)

(choose one)

HPV reflex if ASCUS HPV only - No Pap

HPV w/Pap Screening on women 30 yrs & older No HPV Testing

STD Testing

Chlamydia trachomatis (CT) - 87491

Neisseria gonorrhoea (NG) - 87591

Both Chlamydia trachomatis/Neisseria gonorrhoea

Source

(choose one)

Vaginal _____

Cx/Endo CX Other _____

Clinical Information

(check all that apply)

LMP _____

Pregnant Hormone Rx

Post Partum Laser Surgery

Hysterectomy, total Radiation Rx

Hysterectomy w/intact cervix Patient History - Considered to be at risk?

Post-Menopausal Previous Cryotherapy

Birth Control Pills Previous Biopsy

Birth Control Ring Abnormal Bleeding

Depo-Provera Vaginal Irritation

Estrogen Therapy Previous History of HPV/Dysplasia

IUD Other (specify) _____

Physician's Diagnosis

(circle all that apply)

ROUTINE (SCREENING) — MEDICARE REQUIRES PATIENT SIGNATURE ON ABN

Screening (No signs of symptoms or disease)

Z12.4 Routine screening cervical pap

Z01.419 GYN exam routine without abnormal findings

Z01.411 GYN exam routine with abnormal findings

Z77.9 Other contact with and exposures hazardous to health

Z12.72 Routine screening vaginal pap

Z12.89 Screening for malignant neoplasm of other sites

Diagnostic (signs or symptoms of disease)

R87.619 Unspecified abnormal cytological findings cervix	N87.0	CIN I - mild cervical dysplasia
R87.610 ASCUS	N87.1	CIN II - moderate cervical dysplasia
R87.612 LGSIL on pap	D06.9	Carcinoma in situ cervix
R87.613 HGSIL on pap	N92.6	Irregular menses
R87.810 High Risk HPV DNA test positive	N95.0	Post menopausal bleeding
R87.614 Pap smear cervix with cytologic evidence of malignancy	N95.9	Unspecified menopausal and perimenopausal disorder
R87.618 Other abnormal pap smear of cervix	C53.0	Endocervix CA
R87.628 Other abnormal pap smear of vagina	C53.1	Exocervix CA
N87.9 Dysplasia of cervix, unspecified	Other DX:	_____

Patient History

Previous Pap Results: Within normal limits Abnormal Date: _____

Previous Biopsy Results: _____ Date: _____

SUBMIT ANY SURGICAL & GYN CYTOLOGY SPECIMENS FOR SAME PATIENT TOGETHER TO PLS

FOR LAB USE ONLY

CY _____ C _____
 CYTOLOGIC DIAGNOSIS COMMENTS

AQ _____ D _____ DR _____
 ADEQUACY CYTOLOGIC DIAGNOSIS-MODIFIERS PATHOLOGIST/CYTOTECH

THIN PREP VIAL
 REC'D BY _____
 # SLIDES REC'D _____
 SLIDES REC'D BY _____
 DATA ENTRY BY _____
 RESULT ENTRY BY _____