Three Rivers Pathology
2664 Patton Road
Roseville, MN 55113

Cytology Requisition

Phone: 651-635-9700

Patient Name (Last) **(First)**

Address

City **State** **Zip**

Chart # **SS #** **Phone #**

Clinician Name

/ /
Date Collected

/ /
Date of Birth

Bill: ❑ Clinic ❑ Insurance ❑ Patient
Relationship to insured: ❑ Self ❑ Spouse ❑ Dependent
Primary Insurance ______
Policy # ______
Group # ______
Subscriber Name (if different than patient) ______

Relationship to insured: ❑ Self ❑ Spouse ❑ Dependent
Secondary Insurance ______
Policy # ______
Group # ______
Subscriber Name (if different than patient) ______

Test ordered:

- ❑ Pap and Reflex Low & High Risk HPV (HPV will be done only if pap result is ASC-US)
  - ❑ Reflex HPV Genotyping *Genotypes identified if HPV is positive*
- ❑ Pap and Reflex High Risk HPV (HPV will be done only if pap result is ASC-US)
  - ❑ Reflex HPV Genotyping *Genotypes identified if HPV is positive*
- ❑ Pap Test
- ❑ DNA with Pap (Primary Screening) *(ACOG-recommended-Level A: >30 years old – both Pap and HR/HPV performed)*
  - ❑ Reflex HPV Genotyping *Genotypes identified if HPV is positive*
- ❑ HPV Test (Low Risk & High Risk)
  - ❑ Reflex HPV Genotyping *Genotypes identified if HPV is positive*
- ❑ HPV Test (High Risk Only)
  - ❑ Reflex HPV Genotyping *Genotypes identified if HPV is positive*
- ❑ Chlamydia/Gonorrhea
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Cystic Fibrosis *(must complete supplemental requisition)*
- ❑ Thrombophilia *(must complete supplemental requisition)*

Pap Source: ❑ Cervical ❑ Vaginal ❑ Endocervical

Diagnosis Options: (Check One- Routine is the Default Option)

- ❑ Screening (Routine) V76.2
- ❑ Screening (Potential High Risk) V15.89
- ❑ Diagnostic - list ICD9 Code and DX ______

Patient History: Date of Last Menstrual Period ____ / ____ / ____ (1ST Day of Last Cycle)
Date of Last Pap ____ / ____ / ____ Results ______

Check all that apply

- ❑ Post Menopausal
- ❑ Perimenopausal
- ❑ Pregnant
- ❑ Post Partum
- ❑ Hysterectomy
  - ❑ Cervix Present
- ❑ Depoprovera
- ❑ Hormone Replacement Therapy
- ❑ Prescription Contraceptives
- ❑ IUD
- ❑ OTC Menopausal Relief Agent
- ❑ Other ______
- ❑ High Risk
- ❑ Abn. Bleeding
- ❑ Prev. Abn. Pap Date/DX ______
- ❑ Prev. Colpo. Date/DX ______
- ❑ STD Type ______
- ❑ DES
- ❑ Cancer Type ______
- ❑ Radiation/chemo

Non-Gyn Test ordered:

- ❑ Urine (specify Voided or Catheterized)
- ❑ FISH (urine)
- ❑ Urine and Reflex to FISH (FISH will be done if the cytology result is atypical or suspicious)
- ❑ Breast Cyst Fluid
- ❑ Breast Discharge, Smear
- ❑ FNA (specify source & location)
- ❑ Body Fluid (specify Pleural/Peritoneal)
- ❑ Other (specify source & location)

Clinical Information:
(previous malignancy, size, location, etc.)

Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines. Tests ordered must include patient diagnosis, symptom, or reason for testing. If testing does not come under the Medicare guidelines for payment, a signed Advanced Beneficiary Notice (ABN) must be obtained.

❑ **ABN obtained - Conventional pap test** ❑ **ABN obtained - Liquid based pap test**
❑ **ABN not obtained - last pap greater than two years ago**