Mercy Lab

Gynecological Cytology Requisition Form

phone 800.755.7886
fax 833.752.3788

COLLECTION:

Date _____ Time _____

Patient

Patient Last Name	Legal First Name	MI		
Birthdate *(MO/DAY/YR)*	**Age**		**Sex**	**Social Security #**

Physician

Physician *(print)* Last Name	First Name	Phone # / Fax #	☐ Copy to Dr. _____ ☐ Call to #_____ ☐ Fax to #_____
Physician Address			

Billing — Insurance *(attach copy of insurance card OR complete all information below)*

Insurance _____ Employer _____

Member I.D.# _____ Group #_____ SS # _____

Member Name _____ ☐ Self ☐ Spouse ☐ Child

Address _____

Secondary Ins. _____ I.D.# _____ Group # _____

Symptom or Diagnosis (ICD-10) Code *(required for each test ordered)*

Gynecological Cytology *(All testing performed on PAP vial)*

☐	LAB3603 Cerv/Vag Cyto Age Based Screen Pap	☐	LAB3188 HPV High Risk Detection
☐	LAB3604 Cerv/Vag Cyto Age Based Screen Pap W CT/NG	☐	LAB3189 HPV W/ Reflex Genotypes 16/18/45
☐	LAB3605 Cerv/Vag Cyto Age Based Screen Pap W CT/NG, Trich	☐	LAB3016 HPV Genotypes 16/18/45
☐	LAB3213 Cerv/Vag Cyto Screen Pap w/o HPV	☐	LAB2744 Chlamydia and GC, Pap Vial
☐	LAB3214 Cerv/Vag Cyto Screen Pap w/ HPV	☐	LAB3442 Trichomonas Vaginalis, Qualitative, Pap vial
☐	LAB3216 Cerv/Vag Cyto Screen Pap RFLX HPV	☐	

LMP: _____/_____/_____	Source:	☐ Cervix (Cx)
Previous PAP: _____/_____/_____		☐ Endocervix (ECC)
Previous Bx: _____/_____/_____		☐ Vagina (VG)

Check all that apply:			APNL	☐	Normal exam
APMT7	☐	7 yrs or more since last pap	APPG	☐	Pregnant _____weeks
APHXL	☐	Hx of LSIL or higher Pap/Bx	APPP	☐	Postpartum _____weeks
APHXA	☐	ASC/AGC Pap/Bx w/in 2 yrs	APBCF	☐	Oral contraceptives
APMB	☐	Postmenopausal bleeding	APERT	☐	Estrogen therapy
APCB	☐	Postcoital bleeding	APHO	☐	Hormone therapy
APXM	☐	Abnormal Gyn exam (e.g. HPV infection/Hx/Rx)	APPM	☐	Postmenopausal
APHXP	☐	HPV infection/Hx/Rx	APHYT	☐	Hysterectomy total
PCA	☐	Gyn malignancy; Hx/Rx	APHYC	☐	Hysterectomy with intact cervix