

CYTOPATHOLOGY - GYNECOLOGICAL CONSULT REQUEST

Outreach Clinics Only:

MIM # 1084

Clinic Code _____

Clinic Location _____

| | | | |
|---------------------------------------------------------------------------|-----------------|--------------|----------|
| Collection Date | Collection Time | Collected By | |
| Requesting MD | | MD Code | Beeper # |
| DIAGNOSIS/ CLINICAL INFORMATION (Relevant Findings, Previous PAP Results) | | | |

| TESTING REQUESTED | ICD10 Code(s) |
|-------------------------------------------------------------------------------------------------------------------------------|---------------|
| <input type="checkbox"/> Diagnostic PAP (order when clinical disease state suspected & supported by ICD10 Code) | |
| <input type="checkbox"/> Screening PAP (limited to 1 every 2 yrs for Medicare, Medicaid, TriCare) | |
| <input type="checkbox"/> High Risk Screening (< 16 yr & sexually active, multiple sex partners, history of STD, DES Exposure) | |
| <input type="checkbox"/> HPV Testing | |
| <input type="checkbox"/> HPV Reflex (Current ASCUS Diagnosis Only) | |

SPECIMEN SOURCE Vaginal Cervix Endocervix Vulvar Scraping

| HISTORY FOR GYN SMEARS (Check All that Apply) | QUALITY OF SPECIMEN <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory Due To: |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Yes LMP ____/____/____ | <input type="checkbox"/> Excess Blood |
| Concomitant Tissue Biopsies Taken | <input type="checkbox"/> Obscuring Inflammation |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Poor Preservation |
| <input type="checkbox"/> Post Partum/ Lactating | <input type="checkbox"/> No Endocervical Epithelium |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Smears Excessively Thick |
| <input type="checkbox"/> Menopause Date _____ | <input type="checkbox"/> Smears Dried Before Fixation |
| <input type="checkbox"/> Hysterectomy Date _____ | <input type="checkbox"/> Inadequate Cellularity |
| <input type="checkbox"/> Radiation/ Chemotherapy Date _____ | <input type="checkbox"/> Actinomyces |
| <input type="checkbox"/> Treatment for Dysplasia Procedure Date _____ | <input type="checkbox"/> Yeast |
| <input type="checkbox"/> IUD In Place | <input type="checkbox"/> Trichomonads |
| <input type="checkbox"/> DES Exposure | <input type="checkbox"/> Coccobacilli |
| <input type="checkbox"/> Hormones Specify _____ | <input type="checkbox"/> Herpes |

Cytotech Diagnosis:

Cytopathologist Diagnosis:

Cyto Tech: _____ Date: _____ Time: _____ Cytopathologist: _____

Medicare Patient: Yes No

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a)(1) of the Medicare Law. When ordering tests for which Medicare reimbursement will be sought, physicians should order only those individual tests that are necessary for the diagnosis and treatment of a patient, rather than for screening services.

I certify that this test ordered is medically necessary.

Ordering Provider Signature _____ Date _____ Time _____