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| **CYTOLOGY REQUEST FORM** |
| ABN Required YES ABN Required YES INITIALS  | INDICATION FOR TEST REQUIRED SIGNATURE REQUIREDPHYSICIAN/ADVANCED PRACTICE NURSE (SPECIMEN WILL BE RETURNED IF SIGNATURE NOT PRESENT) |
| **PAP SMEAR PERFORMED BECAUSE:** (Check appropriate box)€ DIAGNOSTIC PAP **CO-TESTING HPV** (SIGNS AND SYMPTOMS OF DISEASE)€ SCREENING PAP **REFLEX HPV TESTING** (ABSENCE OF SIGNS AND SYMPTOMS OF DISEASE) | **NON GYN & FINE NEEDLE ASPIRATION** |
| **PULMONARY** SPUTUM BRONCH WASH \_RT \_ LT BRONCH BRUSHING \_\_ RT \_\_ LT BAL RT LT  | **FLUIDS** ABDOMINAL \_\_RT \_\_LT PLEURAL \_\_RT \_\_LT PERICARDIAL CSF\_\_\_\_\_ CYST, AREA :\_\_\_\_\_\_\_\_\_\_ URINE CATH VOID  BREAST ASPIRATIONOTHER  **FNA** LUNG \_\_ RT \_\_\_\_ LT THYROID \_\_ RT \_\_\_ LT BREAST \_\_ RT \_\_\_\_ LT\_\_\_\_ PANCREAS \_\_ RT \_\_\_\_ LT\_\_\_\_ LIVER \_\_ RT \_\_\_\_ LTOTHER    |
| **PAP SMEAR \*ELECTRONIC ORDER PREFFERED\*** |
|  **PAP SMEAR MENSTRUAL CYCLE** CERVICAL NORMAL ENDOCERVICAL IRREGULAR VAGINAL ABNORMAL BLEEDING HORMONE EVAL MENOPAUSAL(Must be from Upper Lateral Vaginal POST MENOPAUSAL Wall)**SEX** € MALE € FEMALE AGE LMP CURRENT BIRTH CONTROL TYPE ESTROGEN PREGNANT Yes No 1st Trimester 2nd 3rd IUD GRAVIDA PARA AB POST PARTUM DELIVERY DATE GYN SURGERY HYSTER PREVIOUS SMEAR RESULTS DATE  |
| **SPECIAL STAINS**(Boxes must be checked for Special stains to be performed) SILVER (CMS) OTHER**GROSS DESCRIPTION** (Lab Only)    |
| PREVIOUS BIOPSY RESULT DATE  |  **CLINICAL INFORMATION**(PERTINENT CLINICAL HISTORY AS REQUIRED BY CLIA REGULATIONS)   |
| The pap smear is not a diagnostic procedure and should not be used as the sole means to detect cervico-vaginal cancer. It is only a screening procedure to aid in the detection of cervico-vaginal cancer and its precursors. Both false-positive results have been experienced. |

Form# 10255 (05/23) **CYTOLOGY REQUEST FORM**

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