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| **CYTOLOGY REQUEST FORM** | | | |
| ABN Required YES  ABN Required YES  INITIALS | INDICATION FOR TEST REQUIRED  SIGNATURE REQUIRED  PHYSICIAN/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 ASPIRATION  OTHER    **FNA**  LUNG \_\_ RT \_\_\_\_ LT  THYROID \_\_ RT \_\_\_ LT  BREAST \_\_ RT \_\_\_\_ LT  \_\_\_\_ PANCREAS \_\_ RT \_\_\_\_ LT  \_\_\_\_ LIVER \_\_ RT \_\_\_\_ LT  OTHER |
| **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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