

CLIENT NAME AND ADDRESS

 Date Collected: _____ Time Collected: _____



**OBSTETRICS & GYNECOLOGY
 TEST REQUISITION**

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PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 DATE OF BIRTH: (MM/DD/YYYY) _____ SEX _____ SOCIAL SECURITY NUMBER _____ PHONE (H) _____ PHONE (C) _____

INSURANCE INFORMATION

Commercial Medicare Medicaid Bill Patient Bill Client W/C (Date of Injury): _____

NAME OF INSURED (IF DIFFERENT FROM PATIENT) _____ PATIENT RELATIONSHIP TO INSURED:
 SELF SPOUSE DEPENDENT

PRIMARY INSURANCE NAME AND PLAN _____ POLICY NUMBER _____

EMPLOYER/GROUP NAME _____ ORDERING PHYSICIAN'S SIGNATURE:
 (required for Medicaid) _____

HIV TESTING

The following must be provided. I provided pre-test counseling in accordance with Article 27-F of the N.Y. Public Health Law. Questions about the test were answered for the individual whose informed consent was obtained. A copy of this form was offered to him/her.

Authorized Signature Required

ICD9-DX CODES

I request that payment of any third party payer benefits be paid on my behalf to Genesis for services furnished to me by Genesis. I authorize Genesis to release to its agents, and/or other third party payers I any information needed to determine these benefits payable for related services.

Signature of Patient or Patient Representative / Relationship to Patient

SPECIMEN INFORMATION

Source: CERVICO-VAGINAL VAGINAL POOL OTHER: _____
 Type: LIQUID-BASED PREPARATION FLUID SLIDES/SMEARS STAINED TYPE OF STAIN: _____

PATIENT HISTORY

Routine Screen LMP (date): _____ Normal Abnormal Bleeding High Risk
 Pregnant Post Partum Post AB Menopausal for _____ years Hysterectomy
 Gravida: _____ Para Other: _____ IUD in Place
 Oral Contraceptives (type) _____ Previous Dysplasia Estrogen Progesterone Discharge
 Radiation Therapy Vaginitis

CERVIX

Normal Cervicitis Erosion Polyp Leukoplakia Bleeds on Contact Clinically Suspicious Cervical Stump

PAP HISTORY

Previous PAP (date): _____ PAP Classification (check one): NILM ASC-US AGC AIS LSIL HSIL CA Comments: _____
 ASC-US - Atypical squamous cells of undetermined significance. HSIL - High-grade squamous intraepithelial lesion. NILM - Negative for intraepithelial lesion or malignancy. II AGC Atypical glandular cells LSIL - Low-grade squamous intraepithelial lesion. AIS - Adenocarcinoma in situ (endocervical). CA - Cancer.

TISSUE PATHOLOGY

Clinical Diagnosis:
 Source: Cervix Endometrium Vaginal/Vulva Other: _____
 Specimen Type: E.M.C. E.C.C. L.E.E.P. Cervical Punch Biopsy Endometrial Biopsy Vaginal Biopsy POC POC, Chromosome Analysis Other: _____

GYN CYTOLOGY AND MOLECULAR STUDIES

All tests in this section are run from the ThinPrep vial unless otherwise noted. All ThinPrep Tests are image-directed.

9102-5 ThinPrep Pap +HPV (Run on any diagnosis) 1962-0 ThinPrep Pap Test 3852-1 Chlamydia
 9235-3 ThinPrep Pap +HPV +Chlamydia+Gonorrhea 0304-6 HPV (High/Low Risk) 3853-9 Gonorrhea
 6629-0 ThinPrep Pap (Reflex to HPV when ASC-US) 3910-7 HPV (High Risk Only) 5093-0 BV/Vaginitis Assay - (BD Swab)
 6630-8 ThinPrep Pap (Reflex to HPV when ASC-US or greater) 4008-9 HPV (High/Low Risk) - (Swab) (Trichomonas V. Candidia Sp., Gardnerella V.)
 9241-1 ThinPrep Pap +Chlamydia+Gonorrhea 3851-3 Chlamydia+Gonorrhea 0202-2 Group B Strep by PCR- (Culturette)

CYTOPATHOLOGY - NON-GYNECOLOGICAL

FNA Specimens 5242-3 ThinPrep Non-GYN (Preferred)
 5243-1 Alcohol
 Breast Left Right
 Breast Smear Left Right
 Thyroid Left Right
 Other: _____

Other Specimens 5244-9 ThinPrep Non-GYN (Preferred)
 5245-6 Alcohol
 Bronchial Washing Left Right
 Pleural Fluid..... Left Right
 Nipple Discharge..... Left Right
 Paracentesis/Ovarian..... Left Right
 CSF (Not available by ThinPrep) Sputum Other: _____

5254-8 Urine Cytopathology ThinPrep (Preferred)
 2100-6 Urine Cytopathology Alcohol

ADDITIONAL NOTES / INSTRUCTIONS:

