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APA COURIER BARCODE V-2506

Date Received: _____

Accession #: _____

DATE COLLECTED	PHYSICIAN SIGNATURE / INITIAL	DUPLICATE REPORT TO:	RUSH CALL / FAX NUMBER

PATIENT

PATIENT NAME (LAST)	(FIRST)	(M.I.)	SEX

STREET ADDRESS	CITY	STATE	ZIP

CHART # / MEDICAL RECORD #	SOCIAL SECURITY NO.	DATE OF BIRTH	TELEPHONE NO.	WORK NO.

INSURANCE

PLEASE ATTACH COPY OF INSURANCE CARD	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Insurance Company Street Address		
Insurance Company City, State, Zip		
Patient ID # or SSN		
Group #		
Responsible Party and Relationship		
Employer / Address / Phone #		

HISTOLOGY / NON-GYN CYTOLOGY

SOURCE

☐ Excision ☐ Incision ☐ Punch ☐ Curettage ☐ Scissor ☐ Shave ☐ Other_____

☐ Sputum ☐ Bronch Brush (Left) (Right) ☐ Bronch Wash (Left) (Right) ☐ BAL ☐ Urine (☐ Voided ☐ Catherized)

☐ Pleural Fluid ☐ Ascitic Fluid ☐ CSF ☐ Breast Smear (L/R) ☐ FNA (Source)_____ ☐ Other_____

ANCILLARY TESTING

☐ FISH

☐ FLOW CYTOMETRY

SPECIMENS SUBMITTED

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Clinical History

Time Removed **Time Placed In Formalin**

Pre-Op Diagnosis

Post-Op Diagnosis

GYN CYTOLOGY / MOLECULAR TESTING

PAP	SOURCE	ANCILLARY TESTING	
☐ Liquid Based Pap Test	☐ Cervical / Endocervical ☐ Vaginal ☐ Other _____	☐ HPV - High Risk ☐ Chlamydia trachomatis / Neisseria gonorrhoeae	☐ Trichomonas vaginalis ☐ Mycoplasma genitalium

CLINICAL HISTORY

LMP	PREVIOUS PAP HISTORY	PREVIOUS BIOPSY
	Abnormal History ☐ Yes ☐ No Result & Date ☐ Normal Date	Result & Date

MENSTRUAL / PREGNANCY HISTORY		HORMONAL HISTORY	TREATMENT HISTORY	
☐ Hysterectomy	☐ Post Menopausal	☐ Estrogen Replacement Therapy	☐ Cryosurgery	☐ Leep
☐ Hysterectomy (cervix intact)	☐ Amenorrhea	☐ Oral Contraceptive	☐ Conization	☐ Radiation
☐ Pregnant / Wks_____	☐ Post Partum / Wks_____	☐ Depo-Provera	☐ D & C	☐ Other_____
☐ Abnormal bleeding / Spotting	☐ Other_____	☐ Other _____	☐ Date_____	_____

ADDITIONAL HISTORY

☐ IUD ☐ Lesion or Mass ☐ Prior Carcinoma

☐ Discharge ☐ Chemotherapy ☐ Other_____

☐ Colpo Abnormality ☐ Immunosuppressed _____

NOTES:

REFERRING DIAGNOSIS ICD 10 Code:_____

FOR MEDICARE PATIENTS WHO HAVE HAD ROUTINE SCREENINGS WITHIN THE LAST TWO YEARS, AN ABN IS REQUIRED.