SPOKANE (509) 892-2700/(888) 814-6277
FAX (509) 892-2740
TUKWILA (425) 646-0922/(877) 288-0922
FAX (425) 646-0925
RICHLAND (509) 392-5920/(833) 369-7268
FAX (509) 866-5020

LAB NUMBER

CHART #/MRN	DATE OF COLLECTION	SEX
		☐ M ☐ F

PATIENT'S NAME (Last Name, First Name, Middle Initial)

ADDRESS

CITY	STATE	ZIP	PHONE

Clinician

PATIENT SOCIAL SECURITY # ☐☐☐☐☐☐☐☐☐

PATIENT BIRTHDATE

COPY TO: First Name Last Name Location/Phone

INSURANCE DETAILS (Attach Front/Back Copy of Insurance Card) If patient is a minor, provide copy of a parent's insurance card

INSURANCE NAME: POLICY/SUBSCRIBER ID #: VA AUTHORIZATION #

CLAIMS ADDRESS: GROUP #:

☐ NO INSURANCE, BILL PATIENT
☐ CLINIC DIRECT BILL

REQUIRED BREAST SPECIMEN INFORMATION

DATE OF COLLECTION	TIME BREAST TISSUE REMOVED	TIME BREAST TISSUE PLACED IN FORMALIN
	:	:

ICD-10 CODE(S) REQUIRED PLEASE INDICATE DIAGNOSIS CODE(S) RELATING TO THE CURRENT PROCEDURE

TISSUE/BIOPSY

A _____

B _____

C _____

D _____

E _____

Pre-/Postoperative Diagnosis & Clinical History

LAB USE

PAP BLOODY Y N
PAP BRUSH Y N

PAP TESTING

☐ Pap Test - Cervix/Endocervix
☐ Pap Test - Vagina
☐ Pap Test - Anus

LMP Date

Last Pap Date

Last Pap Results
☐ Negative ☐ ASCUS
☐ LSIL ☐ HSIL

Patient History

☐ Contraceptive Mgmt ☐ Hysterectomy ☐ Cervical Stump ☐ Menopausal ☐ Pregnancy ☐ Postpartum ☐ Nursing ☐ Cervix Grossly Abnormal ☐ Hormone Rx
☐ Cryotherapy/Laser Rx ☐ Radiation Rx ☐ Personal Hx Cancer, Type:_____ ☐ High Risk ☐ IUD ☐ Abnormal Bleeding ☐ DES Exposure ☐ Conization

HIGH RISK HPV TEST OPTIONS - MARK ALL THAT APPLY

☐ If Pap result is ASCUS, ASC-H
☐ REGARDLESS of Pap result
☐ If Pap result is ASCUS/LGSIL
☐ Other:_____
☐ Reflex HPV 16, 18/45 Genotyping (if High Risk HPV Positive)
☐ HPV only (no Pap test)

CHLAMYDIA / GONORRHEA / TRICHOMONAS/GBS TEST OPTIONS Separate ICD-10 Code(s) required

ICD-10 Code(s)

☐ Gonorrhea only
☐ Chlamydia only
☐ Trichomonas vaginalis
☐ Group B Strep by RT-PCR (GBSPCR) ☐ Antibiotic susceptibility if positive (for Penicillin allergic patient)
☐ Chlamydia & Gonorrhea
☐ Chlamydia/Gonorrhea/Trichomonas

VAGINITIS/VAGINOSIS BY APTIMA® MULTITEST SWAB

☐ **Aptima BV Assay ® (BVTMA)**
(Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus spp.)

☐ **Aptima CV Assay ® (CVTMA)**
(Candida spp., Candida glabrata)

☐ **Aptima CV/TV Assay ® (CVTVTMA)**
(Candida spp., Candida glabrata,Trichomonas vaginalis)

☐ **Aptima VP Assay ® (VPTMA)**
(Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus spp.,Candida spp., Candida glabrata,Trichomonas vaginalis)

☐ **Mycoplasma genitalium (MYCO-G)**

VAGINITIS TEST OPTIONS BY THINPREP® PAP

☐ **Vaginitis Panel (VAG-P)**
☐ Candida albicans (CAND-A)
☐ Gardnerella vaginalis (GARD-V)
☐ Trichomonas vaginalis (TRICH-V)

Separate ICD-10 Code(s) required for Vaginitis/ Vaginosis test options

☐ Herpes Simplex Virus (HSV1/HSV2) (CYTO-HSV) Lesion swab in Universal Transport Medium

NON-PAP CYTOLOGY SPECIMENS

☐ Fine Needle Aspiration, Source: _____ Urine: ☐ Voided ☐ Instrumented

Respiratory Cytology: ☐ Sputum ☐ BAL ☐ Brushings ☐ Washings Location: _____ ☐ Pelvic Washings ☐ Endocervical Brushings ☐ Nipple Discharge (☐L☐R)

Effusion Fluid: ☐ Pleural (☐L☐R) ☐ Ascites ☐ Location: _____ ☐ Other: _____

AFFIX LABEL(S) TO SPECIMEN CONTAINER(S) WITH FULL PATIENT NAME AND SPECIMEN SITE