5802 Wright Dr.
Loveland, CO 80538
(800) 920-6227 or (970) 212-0530
(970) 212-0553 Fax

www.summitpathology.com

Name ______________________ D.O.S. ____________
LAST (Please Print) FIRST

Address ______________________ Physician____________

______________________ D.O.B. ____________
CITY STATE ZIP

SSN #: ____________ Sex: ☐ Female ☐ Male Patient Acct #: ____________

Copy To ____________ Patient Phone # ____________

Insurance Card Copy REQUIRED (Front & Back)

☐ Patient ☐ Insurance (See Attached) ☐ Medicare ____________ ☐ Medicaid ____________

PAP TEST

PAP TEST

NO PAP TEST

☐ **STAT**

☐ Dr. Desk

Please check "Pap" or "No Pap" Test

HPV Testing (Screening and 16/18 Genotypes)
- ☐ ASCUS Only
- ☐ ASCUS and Above
- ☐ ANY DIAGNOSIS
- ☐ DNA w/ pap (age 30 and over)
- ☐ **NO** reflex HPV testing
- ☐ HPV **ONLY** (no Pap test)

CT/NG Testing
- ☐ Chlamydia (CT) only
- ☐ Gonorrhea (NG) only
- ☐ **Both** CT & NG testing
- ☐ NO reflex CT/NG testing

CF Testing
- ☐ Cystic Fibrosis (CF)

Herpes Testing
- ☐ Herpes Simplex Virus

Vaginosis Pathogens (if no separate specimen sent, it will be taken from the pap vial)
- ☐ Gardnerella, Candida, Trichomonas

Vaginosis Pathogens with Tier 2 reflex (pap vial only)
- ☐ Gardnerella, if negative reflex Atopobium vaginae
Candida, if positive reflex to Candida species profile
Trichomonas

☐ **Group B Strep (pap vial only)**

PATIENT HISTORY **REQUIRED INFORMATION

PATIENT HISTORY

****REQUIRED INFORMATION****

LMP ____________ **ICD 9** ____________
(Reason for visit)

Date of Last Pap: ____________

Last Pap/HPV Diagnosis: ____________

Specimen Source
- ☐ Vaginal
- ☐ Cervical
- ☐ Endocervical
- ☐ Other ____________

- ☐ History of Abnormal Pap Tests
- ☐ Screening
- ☐ Diagnostic

Clinical History
- ☐ Pregnant
- ☐ Post Partum
- ☐ High Risk
- ☐ Birth Control Pills
- ☐ IUD
- ☐ Depo Provera
- ☐ Post Menopausal
- ☐ Hysterectomy
- ☐ Estrogen
- ☐ Cervicitis
- ☐ Vaginitis
- ☐ Radiation Rx/Chemo

Other: ____________

Non-GYN & TISSUE BIOPSY

NON GYN/TISSUE BIOPSY

- ☐ Breast Cyst (smear or Aspiration)
- ☐ Bronchial Brush
- ☐ Sputum
- ☐ Urine (voided)
- ☐ Urine (catheterized)
- ☐ Fine Needle Aspiration
Site: ____________

- ☐ Cervical Biopsy ____________
- ☐ Endocervical Curretage (ECC)
- ☐ Endometrial Biopsy (EMB)
- ☐ Leep
- ☐ Vulvar Biopsy
- ☐ Vaginal Biopsy
- ☐ Skin Biopsy ____________
- ☐ Other: ____________

Specimen Source(s): ____________

☐ Correlate with Pap Results (if available)

Clinical History: ____________

Hormone Therapy (specify): ____________

Clinical Diagnosis: ____________

Physician Signature ____________