



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

Name _____ D.O.S. _____
LAST (Please Print) FIRST

Address _____ D.O.B. _____

CITY STATE ZIP Provider: _____

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

Copy To _____ Patient Phone # _____

Insurance Card Copy REQUIRED (Front & Back)

☐ Client ☐ Patient ☐ Insurance (See Attached) ☐ Medicare _____ ☐ Medicaid _____

PAP TEST

NO PAP TEST

☐ **STAT**

Please check "Pap" or "No Pap" Test

HPV Testing

- ☐ Pap w/ ASCUS Only ☐ DNA w/ Pap (age 30 and above cotest)
☐ Pap w/ ASCUS and Above ☐ HPV ONLY (no Pap)
☐ Pap w/ HPV (any diagnosis) ☐ Pap only (no HPV testing)

Molecular Testing:

- ☐ Chlamydia & Gonorrhea (CT/NG)
☐ Trichomonas
☐ Vaginosis Panel: Bacterial Vaginosis, Candida, and Trichomonas
☐ Herpes (Type 1 and 2)
☐ Mycoplasma Genitalium

CINtec PLUS Cytology (Thinprep vial only)

- ☐ Pap & HPV w/ Reflex CINtec PLUS (pap normal, HPV positive)
☐ HPV Primary w/ Reflex to CINtec PLUS (HPV positive)

PATIENT HISTORY

****REQUIRED INFORMATION****

LMP _____

Specimen Source

- ☐ Vaginal
☐ Cervical
☐ Endocervical
☐ Other _____

Date of Last Pap: _____

Last Pap/HPV Diagnosis: _____

- ☐ Z01.419 Routine Gynecological Exam ☐ R87.619 Abnormal Pap
☐ Z12.4 Cervical Screening Pap ☐ N89.8 Leukorrhea
☐ Z11.51 Screening for HPV ☐ N76.0 Acute Vaginitis
☐ Z34. _____ Supervision of pregnancy ☐ Z11.3 Screening STD
☐ N87.0 Mild Cervical Dysplasia ☐ Z20.2 Exposure to STD
☐ N87.1 Moderate Cervical Dysplasia ☐ Z39.2 Postpartum visit
☐ R87.610 ASCUS of Cervix
☐ N95.0 Postmenopausal bleeding

Other _____

Clinical History

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

Non-Gyn Cytology

Surgical Pathology Tissue Biopsy

- ☐ Breast Cyst (aspiration or smear)
☐ Bronchial Brush
☐ Sputum
☐ Urine (voided)
☐ Urine (bladder wash)
☐ Urine (catheterized)
☐ Fine Needle Aspiration
☐ Site: _____

- ☐ Cervical Biopsy: _____
☐ Endocervical Curettage (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: _____