ONE CRANBERRY HILL, SUITE 303
LEXINGTON, MA 02421
Telephone: 877-872-8223 Fax: 781-290-0059

SUBMITTING CLINICIAN INFORMATION

____
Office Name

____
Submitting Physician Name

____
Address

____
City State ZIP Code

______________ ______________
Telephone Number Fax Number

PATIENT INFORMATION

______________ Sex: ☐ Female ☐ Male
Date of Birth

____
Name (Last, First, Middle Initial)

____
Address

____
City State ZIP Code

______________ ______________
Telephone Number Medical Record Number (Optional)

BILLING INFORMATION

Primary Insurance	Secondary Insurance
Insurance Company	Insurance Company
Member ID	Member ID
Group Number	Group Number
Insured Name	Insured Name
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SEND ADDITIONAL COPY OF REPORT TO

____
Doctor's Name Address

____
City State ZIP Code

SPECIMEN INFORMATION

SPECIMEN COLLECTION DATE: ______________

☐ **LMP** ______________
☐ **PRIOR ABNORMAL PAP or HPV INFECTION** ______________
☐ **HYSTERECTOMY** ______________
☐ **PREGNANT** ______________
☐ **MENOPAUSE** ______________
☐ **HORMONE THERAPY** ______________
☐ **BIRTH CONTROL** ______________
☐ **NORMAL EXAM** ______________
☐ **ADDITIONAL CLINICAL INFORMATION** ______________________________

____

DIAGNOSIS: ______________________________

PAP SMEAR:
- ☐ **THINPREP®**
- ☐ **CONVENTIONAL**

SPECIMEN SOURCE:
- ☐ **CERVICAL**
- ☐ **ENDOCERVICAL**
- ☐ **VAGINAL**

ADDITIONAL TESTS:
- ☐ **HPV High Risk**
- ☐ **Reflex HPV from ASC**
- ☐ **HPV 16/18**
- ☐ **Reflex HPV 16/18 if NILM/RCC & Positive HPV HR**
- ☐ **Chlamydia/N. gonorrhoeae, ThinPrep**

URINE:
- ☐ **Urine for Cytology**
- ☐ **Urine for FISH**
- ☐ **Urine for C+S**
- ☐ **Urine for Chlamydia/N. gonorrhoeae**

OTHER:
- ☐ **Chlamydia/N. gonorrhoeae Endocx or M/Uret Swab**
- ☐ **FNA:** ______________________
- ☐ **Nipple Discharge**
- ☐ ______________________

TISSUE PATHOLOGY:
- ☐ **CERVICAL EVALUATION**
  - ☐ **Cervix** _____ **o'clock**
  - ☐ **Cervix** _____ **o'clock**
  - ☐ **Cervix** _____ **o'clock**
  - ☐ **Cervix** _____ **o'clock**
- ☐ **ENDOCERVICAL CURETTAGE**
- ☐ **ENDOMETRIAL BIOPSY**
- ☐ **ENDOMETRIAL CURETTAGE**
- ☐ **VULVAR BIOPSY**
- ☐ **VAGINAL BIOPSY**
- ☐ **PRODUCT OF CONCEPTION**
- ☐ ______________________

PRE-OP IMPRESSION: ______________________

PROCEDURE: ______________________

ADDITIONAL SPECIAL TEST(S):

☐ ______________________

☐ ______________________

ICD9 CODE(S): _______ _______ _______ _______