PATHOLOGY CONSULTANTS
specialized diagnostic services

8 MEMORIAL MEDICAL CT., GREENVILLE, S.C. 29605
TEL. (864) 295-3482 / FAX: (864) 295-4817

REFERRED BY

PLEASE PRINT

CHART NO. _____ ACCESSION NO.

PATIENT NAME (LAST) (FIRST)

ADDRESS

CITY STATE ZIP

SSN PATIENT TEL. NO.

SEX ☐M ☐F PHYSICIAN

GYN CYTOLOGY

DATE COLLECTED

☐	**CONVENTIONAL PAP SMEAR**
☐	CERVICAL/VAGINAL/ENDOCERVICAL
	LIQUID BASE PAP SMEAR
☐	VAGINAL
☐	CERVICAL/ENDOCERVICAL
☐	REFLEX to High-Risk HPV for ASCUS
	OTHER MOLECULAR TESTING
☐	Co-Test (PAP + HPV)
☐	HPV Only
☐	CT/GC (OFF VIAL)
☐	CT/GC (PROBE)
☐	CT/GC (URINE)
☐	TRICHOMONAS (NEAT URINE/SWAB)
	COMMENTS

PATIENT HISTORY

D.O.B.

LMP

CHECK ALL THAT APPLY

☐	BCP/IUD
☐	HORMONES
☐	PREGNANT
☐	POST-PARTUM
☐	BLEEDING (ABNORMAL)
☐	DISCHARGE
☐	HYSTERECTOMY: Total, or Supracervical
☐	MATURATION INDEX
☐	RADIATION
☐	CHEMOTHERAPY
☐	PREVIOUS ABNORMAL CYTOLOGY
☐	# (INDICATE NUMBER) _____

NON-GYN CYTOLOGY

☐ FINE NEEDLE ASPIRATE
- ☐ SOLID BREAST MASS L R
- ☐ CYST BREAST ASPIRATE L R
- ☐ THYROID L R
- ☐ LYMPH NODE ORIGIN _____
- ☐ SALIVARY GLAND
- ☐ LUNG L R LOBE _____
- ☐ GI TRACT ORIGIN _____
- ☐ PANCREAS
- ☐ KIDNEY
- ☐ SOFT TISSUE: ORIGIN _____
- ☐ LIVER
- ☐ HEAD & NECK SITE _____
- ☐ PAROTID
- ☐ OTHER _____

☐ URINE VOIDED
☐ URINE CATHETERIZED
☐ NIPPLE SECRETION L R

☐ BODY FLUID: CSF/PLEURAL/PERICARDIAL/PERITONEAL
VOLUME _____ CC
☐ WASHINGS: PELVIC/BRONCHIAL/GASTRIC/BLADDER
☐ BRUSHING: ORIGIN _____
☐ OTHER _____

_____
(PLEASE SPECIFY)

COMPLETE THE FOLLOWING FOR INSURANCE BILLING OR ATTACH COPY OF PATIENTS INSURANCE CARD OR INFORMATION

GUARANTOR NAME (IF OTHER THAN PATIENT)

INSURANCE NAME/ADDRESS

CITY STATE ZIP CODE

EMPLOYER NAME

MEDICARE NUMBER / MEDICAID NUMBER / POLICY # (SUFFIX)

OTHER INSURANCE (GROUP NAME) / NUMBER

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the parties who accept assignment.

PATIENT SIGNATURE DATE

GYNECOLOGIC (PAP TESTING)

APPROPRIATE BOX MUST BE MARKED

NON-MEDICARE PATIENT

Primary Diagnosis Code _____

Secondary (if applicable) _____

MEDICARE PATIENT

Low risk (cervical smear) Z12.4 ☐

Low risk (vaginal smear) Z12.72 ☐

High risk (cervical or vaginal smear) Z77.9 (exposure) ☐ Z92.89 (history) ☐

Diagnostic Code _____

LAB USE ONLY

	ORGANISMS OR CELLS PRESENT		DIAGNOSIS
☐	ENDOCX NOT PRESENT	☐	NEGATIVE
☐	ENDOCX PRESENT	☐	ASCUS
☐	ENDOMETRIAL CELLS	☐	AGUS
☐	SQ METAPLASIA	☐	LSIL
☐	BLOOD	☐	HSIL
☐	BACTERIA	☐	MALIGNANT
☐	CANDIDA	☐	UNSATISFACTORY
☐	TRICH		

	ADEQUACY
☐	SAT
☐	
☐	UNSAT

REMARKS

FP

CT _____

RS _____

PATH

☐ Interpretation billable

CLINICAL INFORMATION _____

Diagnosis Code _____