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) V76.2 ☐

Low risk (vaginal smear) V76.47 ☐

High risk (cervical or vaginal smear) V15.89 ☐

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 _____