



**Instructions:** Send a completed copy of this form with the specimen. Name must be clearly indicated on the specimen and must match paperwork.

**Patient Information** (required)

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient ID (Medical Record Number, if available)		
Referring Provider Name <i>(Last, First)</i>	Phone	Fax*
Other Contact Name <i>(Last, First)</i>	Phone	Fax*

\*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

**Reason for Testing** (required)

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**Complete All Information Below**

Collection Date <i>(mm-dd-yyyy)</i>	Collection Time <i>(hh:mm)</i> <input type="checkbox"/> am <input type="checkbox"/> pm	Last Menstrual Period (LMP) <i>(mm-dd-yyyy)</i>
Source (check one) <input type="checkbox"/> Cervical/Endocervical <input type="checkbox"/> Vaginal	Patient Is (check one) <input type="checkbox"/> Pregnant <input type="checkbox"/> Postpartum <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Surgical procedure hysterectomy	Contraceptives <input type="checkbox"/> Intrauterine Device (IUD) <input type="checkbox"/> Depo-Provera (shot) <input type="checkbox"/> Oral contraceptives
Pertinent Clinical History		

**Papanicolaou (PAP) Smear Testing** Check one test below.

*Screen			**Diagnostic		
TPRPS	<input type="checkbox"/>	ThinPrep Screen, Varies	TPRPD	<input type="checkbox"/>	ThinPrep Diagnostic, Varies
STHPV	<input type="checkbox"/>	ThinPrep Screen with Human Papillomavirus (HPV) Reflex, Varies	DTHPV	<input type="checkbox"/>	ThinPrep Diagnostic with Human Papillomavirus (HPV) Reflex, Varies
STPCO	<input type="checkbox"/>	ThinPrep with Human Papillomavirus (HPV) Co-Test-Screen, Varies	DTPCO	<input type="checkbox"/>	ThinPrep with Human Papillomavirus (HPV) Co-Test-Diagnostic, Varies
CPAPS	<input type="checkbox"/>	Conventional Smear-Screen, Varies	CPAPD	<input type="checkbox"/>	Conventional Smear-Diagnostic, Varies

\* Screen: Routine Exam. No current symptoms. No previous abnormal finding.

\*\* Diagnostic: Previous abnormal Pap findings, signs or symptoms, or has significant complaints related to female reproductive system.  
(\*\*describe above)