CATHOLIC MEDICAL CENTER
100 McGregor Street
Manchester, NH 03102
603-663-8031

CMC LABORATORY LABEL

GYN CYTOLOGY REQUISITION (For Use in Ordering Pap and HPV Testing)

Patient Name: ______________________ **Sex:** M / F **DOB:** ___/___/___

****Please Attach patient demographic sheet . This is necessary for patient registration.**

Requesting Provider: ______________________

Copies to: (Must provide complete name and address) ______________________

Fax: ______________________ **Call:** ______________________

Specimen Information:*	Collection Date:*	Collection Time:	Received Date:	ICD-10 Code:*

Please check *ONE* box in this section:*

☐ Screening Pap: ( ) Routine ( ) High-risk of cervical cancer

☐ Diagnostic Pap

Specimen source:* ☐ **Cervix** ☐ **Endocervix** ☐ **Vagina** ☐ **Other (specify):**______________________

Liquid Based (ThinPrep®) Pap and HPV Testing:

☐ **Pap only (recommended for women age 21-29)[1]**
☐ **Pap with high-risk HPV co-test (recommended for women ages 30-65)[1]**
☐ **Pap with high-risk HPV reflex testing (HPV testing is done for ASC-US diagnosis only)**
☐ **Pap with high-risk HPV testing for all atypical diagnoses**

☐ **High-risk HPV testing only[2]**
☐ **HPV 16/18 genotyping (done only if high-risk HPV test is positive)**

1 Based on recommendations made by the American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP), the American Society for Clinical Pathology (ASCP), the US Preventative Services Task Force (USPSTF), the American College of Obstetricians and Gynecologists (ACOG), and the Society of Gynecologic Oncology (SGO).

2 This laboratory does not conduct high-risk HPV testing as a primary screening method. This option should be used only in situations in which Pap screening results are already available (such as an add-on request).

Clinical Information:

Last Menstrual Period:*______________________ Date of Last Pap:______________________

Previous Abnormal Pap (circle one): Yes / No

If Yes please provide diagnosis and date: ______________________

☐ Total hysterectomy (cervix removed, vaginal specimen source) ☐ Supracervical hysterectomy

☐ Pregnant _____WKS ☐ Post Partum _____WKS ☐ Postmenopausal

☐ IUD Present ☐ Previous Radiation or Chemo ☐ Hormone Therapy/Contraception

☐ DES Exposure ☐ Postmenopausal Bleeding ☐ HPV Vaccination

Additional Clinical History: ______________________

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***Fields marked with an Asterisk are MANDATORY. Specimens submitted without complete information may not be processed.**

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