NEWTON-WELLESLEY HOSPITAL

Newton-Wellesley Hospital Laboratory

2014 Washington Street, Newton, MA 02462 CLIA# 22D0710787 CAP# 11517-01

PARTNERS HEALTHCARE

Patient Last Name	First	MI

Gender M F	Date of Birth / /	Room #

Medical Record Number	Social Security Number - -

Patient Home Address, City, State, Zip Code

Home Telephone	Other Telephone	Subscriber Last Name First MI	Subscriber's Relationship to Patient

Patient Insurance Company Name / Coverage (attach copy of card)	Subscriber Address
Certificate # / Policy # / Group #	❒ CLIENT BILL/FACILITY BILL/PPS to:
Insurance Company Address, City, State, Zip	Send Copies to:_____

Please provide diagnostic information in the form of a valid ICD-10CM code or complete narrative diagnosis which has been documented in the patient's medical record

Order Date / Time
/ / ____ AM / PM

❒ **STAT! Use STAT Bag**

❒ **Call** ( ) -
❒ **Fax** ( ) -

MD Signature: _____

SPECIMEN INFORMATION

Collection Date / Time
/ / ____ AM / PM

Comments to appear on the report:

GYN CYTOLOGY

☐ **Cervical Pap Test*** ☐ **Vaginal Pap Test*** ☐ Anal Pap Test

MOLECULAR HPV ASSAY FROM THINPREP VIAL

☐ No High Risk HPV (recommended for ages 21 – 24)
☐ Reflex High Risk HPV for atypical squamous cells (recommended for ages 25 – 29)
☐ Cotest High Risk HPV (recommended for age 30 +)
☐ Cotest High Risk HPV and reflex HPV 16/18 genotype only if Pap Negative and HR HPV Positive (recommended for age 30 +)

ANCILLARY TESTING FROM THINPREP VIAL

☐ **CTNG RNA*** ☐ **CT RNA*** ☐ **NG RNA*** ☐ **Trichomonas RNA***

CLINICAL HISTORY

LMP:_____(REQUIRED)

☐ Postmenopausal
☐ Total Hysterectomy
☐ Supracervical Hysterectomy
☐ Pregnant
☐ Postpartum
☐ HPV infection
☐ Normal/routine exam
☐ Previous abnormal cytology/biopsy
☐ Abnormal bleeding
☐ IUD
☐ Hormone therapy (not BCP)
☐ Other abnormal history:
_____

NON-GYNECOLOGIC CYTOLOGY

☐ Random/Voided Urine
☐ Catheterized/Cysto Urine
☐ Fine Needle Aspiration Specify site:_____ ☐ L ☐R
☐ Other:_____
Clinical Impression:_____

SURGICAL PATHOLOGY

Tissue submitted:_____
Procedure:_____
Clinical Impression/Reason for Procedure:_____
_____
_____

*Red Denotes Medical Necessity Required

Yellow fields are required to authenticate order

057563 (12/15)