Cayuga HEALTH SYSTEM

Department of Laboratories
Elizabeth Plocharczyk, MD
Director of Laboratories

Cytology #

GYN Cytology Order

PATIENT/PROVIDER INFORMATION Print or Affix Label

Last First MI	DOB ☐ Male ☐ Female
Street	Account #
City State Zip	Date/Time Collected
Provider Signature Date/Time	Ordering Provider
☐ Verbal Order taken & Read back by: (signature) (date/time)	Copies To

☐ Screening Pap
☐ Diagnostic Pap

☐ Bill Insurance (please attach photocopy of patient's insurance card)
☐ Self Pay

CLINICAL HISTORY - REQUIRED

Clinical Diagnosis - History - Symptoms

Diagnosis Code: _____

Reason for Visit: _____

Clinical History (required)

Yes	No	
☐	☐	Pregnant
☐	☐	Post Menopausal
☐	☐	Hysterectomy
☐	☐	Previous Abnormal PAP

If Yes, Diagnosis:

_____

LMP (date required): _____

Other Pertinent History: _____

_____

_____

_____

_____

_____

LAB TEST REQUEST

Source (required)

☐ Ectocervical / Endocervical
☐ Vaginal
☐ Other

Test

☐ Thin Layer Pap with HPV Regardless
☐ Thin Layer Pap with HPV Reflex if ASCUS
☐ HPV Genotyping (if HPV positive)
☐ **GC/Chlamydia from vial**
☐ **Trichomonas from vial**

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