Healthy Driven
Edward-Elmhurst
HEALTHCARE

Test results needed: ☐ Routine ☐ STAT

TO SCHEDULE AN APPOINTMENT CALL: (630) 527-3200 Fax: (630) 527-3099

NON EPIC PAP REQUISITION

Date ________________ Patient Legal Name ____
Last First

Date of Birth ______________ Patient Phone Number ____________________________ Gender ☐Male ☐Female

Physician's Name Choose an item. Physician Phone Number Choose an item.

Physician's Signature ____

DIAGNOSIS REQUIRED (Use signs, symptoms, complaints or previous diagnosis. DO NOT USE "Rule Out", "vs", "Suspected", or "Possible/Probable". Any ICD-10 code must be accompanied by narrative.)

DIAGNOSIS ____

Medicare does not cover routine screening tests. The ordering of medically unnecessary testing including Organ/Disease Panels for Medicare and Medicaid patients may result in significant fines and penalties under the Civil False Claims Act.

NOTES/OTHER ____

CLIENT INFO Choose an item. **SPECIMEN COLLECTION DATE** ________________

Pap & Reflex HPV Testing Options

Option #1

☐Thin Prep PAP with HPV Reflex Request (LAB4465)

HPV Request: ☐HPV if Pap ASCUS

HPV Genotype Request if HPV Positive: (select if desired)

☐Reflex 16, 18/45 if PAP ASCUS or Negative

☐No 16,18/45

OR

Option #2

☐Thin Prep PAP with HPV Reflex Request (LAB4465)

HPV Request: ☐HPV if Pap ASCUS of Negative

HPV Genotype Request if HPV Positive:

☐Reflex 16, 18/45 if PAP ASCUS or Negative

☐No 16,18/45

Pap & HPV Testing

☐Thin Prep PAP Smear (LAB4558)

☐HPV DNA High Risk, Thin Prep Collect (LAB3015)

HPV Genotype Request if HPV Positive: (may select one)

☐Yes ☐If Pap Negative ☐No

STI Testing

☐Chlamydia/GC Amplification, Thin Prep Collect (4183194)

☐Trichomonas Vaginitis by NAA (2188052)

Clinical History

Specimen Source: ☐Endocervix ☐Cervical/Endocervical ☐Cervical/Endocervical/Vaginal ☐Cervix ☐ Vaginal/Cervical ☐Vaginal ☐ Anal

Reason for Testing: ☐Screening ☐ Diagnostic ☐ Screening, High Risk

Last Menstrual Period: ________________

Last Pap Result: ☐Normal ☐ASCUS ☐Low Grade ☐High Grade ☐HPV Pos ☐HPV Neg ☐Unsatisfactory/Limited ☐No History Available ☐Other ________________

Pap History Date: ________________

Menstrual Status: ☐Regular Menses ☐Irregular Menses ☐Abnormal Bleeding ☐Pregnant ☐Post-Partum ☐Peri-menopausal ☐Post-menopausal ☐Total Hysterectomy ☐Supracervical Hysterectomy

Contraceptive/Hormonal Therapy: ☐Diaphragm ☐IUD ☐Tubal Ligation ☐Other/Therapy(Specify): ________________

Physical Findings: ☐Vaginitis ☐ Cervicitis ☐Discharge ☐Abnormal Cervix ☐ Other: ________________

Pap Therapy: ☐D and C ☐Cryotherapy/Laser ☐Conization ☐Radiation/Chemo ☐Other: ________________

Therapy Date: ________________ **Therapy Results:** ________________