Wisconsin State Laboratory of Hygiene
UNIVERSITY OF WISCONSIN–MADISON

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CYTOLOGY 608.262.1297 FAX 608.265.6294 (04/2022) WSLH# 141

PLEASE **PRINT** USING CAPITALS. FIELDS IN RED ARE REQUIRED

(1) Patient Last Name | First Name | Middle Name

(2) Name Change – Former Last Name, Former MRN - if applicable

(3) Patient Address

(4) City | State | Zip | County of Patient's Residence

(5) Date of Birth | (6) Age | (7) ☐ Female ☐ Male

(8) Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino | (9) ☐ Amer Indian ☐ Asian ☐ Black/African Amer ☐ Pacific Islander ☐ White ☐ Other____________

(10) Chart #/Patient ID Number | (11) Submitter Specimen ID Number

(13) Additional Report Copies needed ? Please check this box ☐
AND Enter the clinicians name and contact information on the back of this form.

(14) Ordering Provider

(15) NPI # __ __ __ __ __ __ __ __ __ __

(16) Attached copies of front and back of insurance card(s)? ☐

(17) HAVE YOU PRESENTED AN ADVANCED BENEFICIARY NOTICE (ABN) TO YOUR PATIENT?
☐ Yes: Please submit a copy. ☐ No: Clinic may be responsible for Medicare denial, please call the lab.

(18) BILLING INFORMATION ☐ PRIVATE INSURANCE (please send both sides of card) ☐ BILL CLINIC ☐ TITLE X ☐ RHFP/BA ☐ NO INSURANCE
☐ MEDICAID #____________ Please Specify MA Type: ☐ TE ☐ FPOS ☐ BadgerCare ☐ OTHER ____________
☐ WWWP# ____________ ☐ MEDICARE # ____________(need ABN, see #17)

(19) I authorize WSLH to release my personal information to a Third Party Payer for purposes of billing. I understand that information may be sent from the Third Party to the address of the policy holder.

Patient Signature ____________________ Date: ____________

20) MEDICAL NECESSITY: Please write in the most appropriate code for Pap, HPV, and/or Tissue collection below.

(A) ☐ ICD-10Code **Z30.09** **CHECK (A) FOR FAMILY PLANNING ONLY SERVICES** (B) ICD10 ________ (C) ICD10________ (D) ICD10________ (E) ICD10________

(21) Date of Collection | (22) Time of Collection: ☐

LMP: ____/____/____ ☐ UNKNOWN ☐ POSTMENOPAUSAL ☐ SECONDARY AMENORRHEA

PAP & HPV LAB TEST ORDERS

SOURCE: ☐ Cervical ☐ Cervical/Endocervical ☐ Cervical/Vaginal ☐ Vaginal ☐ Anal ☐ Vulva ☐ Endocervical ONLY ☐ Other____________

PAP TEST: ☐ Liquid Base ☐ Conventional ICD10: ____________
☐ Screening Pap Test (Routine Visit, Low Risk for Cervical Cancer)
☐ Diagnostic Pap Test (Previous Cervical Abnormalities, High Risk for Cervical Cancer)

HPV TEST: (HPV Test Orders Supersede Standing Orders) ICD10: ____________
☐ HPV Regardless of Diagnosis ☐ HPV Reflex with an ASCUS PAP result
☐ HPV ONLY - For Pap Test Follow-up ☐ NO HPV - Do NOT Reflex

HPV PRIMARY SCREENING: ICD10: ____________
☐ HPV Primary Screening Protocol (Pap Reflex if HPV+) Specimen Source: ☐ Cervical

☐ Self-Collect HPV (NO Pap Reflex) - Specimen Source: ☐ Vaginal Swab
Vaginal Swab Type: ☐ FLOQSwab® ☐ Evalyn® Brush

HISTOLOGY LAB TEST ORDERS

SPECIMEN(S) SUBMITTED: Each specimen vial should be labeled with matching **PID** (two forms), and the specimen source. Please note the specimen source under **Body Site** in the table below. The **Specimen** column is for lab use and can be left blank

SPECIMEN	PROCEDURE	BODY SITE	CLINICAL IMPRESSION
	☐ Biopsy ☐ Brushing ☐ Punch ☐ D&C ☐ Cone Biopsy ☐ LEEP/LOOP Other:		
	☐ Biopsy ☐ Brushing ☐ Punch ☐ D&C ☐ Cone Biopsy ☐ LEEP/LOOP Other:		
	☐ Biopsy ☐ Brushing ☐ Punch ☐ D&C ☐ Cone Biopsy ☐ LEEP/LOOP Other:		
	☐ Biopsy ☐ Brushing ☐ Punch ☐ D&C ☐ Cone Biopsy ☐ LEEP/LOOP Other:		
	☐ Biopsy ☐ Brushing ☐ Punch ☐ D&C ☐ Cone Biopsy ☐ LEEP/LOOP Other:		

CURRENT CLINICAL FINDINGS

☐ Abnormal Bleeding ☐ Bacterial Vaginitis ☐ Candida ☐ Cervicitis ☐ Chlamydia
☐ Friable Cervix ☐ GC ☐ HSV ☐ HPV ☐ Trich ☐ Perimenopause
☐ Hysterectomy (☐ BSO ☐ LSO ☐ RSO) ☐ **COLP TODAY**
☐ Other

Currently Pregnant? ☐ No ☐ Yes, How Many Weeks? ____________

Post Partum? ☐ No ☐ Yes, How Many Weeks? ____________

Gravida ________Para________Ab________

CONTRACEPTION & HORMONE THERAPY

☐ Oral Contraception ☐ Depo-Provera/Other injection ☐ Vaginal Ring ☐ Condoms
☐ IUD (☐ Mirena ☐ Paragard ☐ Other) ☐ Implanon ☐ HRT
☐ Secondary Amenorrhea (Specify Cause Below) ☐ Other (Please specify)

CLINICAL HISTORY / PROCEDURES

	Date / Result		Date / Result
☐ Biopsy	____________	☐ D&C	____________
☐ ECC	____________	☐ LEEP	____________
☐ Colp	____________	☐ Cone	____________

☐ Other (Please Specify):

PREVIOUS PAP/HPV TEST: ☐ First Pap ☐ State Lab ☐ Elsewhere

☐ Normal ☐ Abnormal Date/Result: ____________

☐ HPV POS ☐ HPV NEG Date: ____________

ADDITIONAL COMMENTS:

Copies To:
Name
Address
City, State Zip

Copies To:
Name
Address
City, State Zip

Please print in black ink; use CAPITAL letters; complete all fields in "red" on the requisition.

FIELD	NOTES
REQUIRED 1.	Print the patient's full legal name. (Last name, first name, and middle).
2.	Provide former last names, if applicable. (Helps us maintain patient records)
REQUIRED 3.	Print the patient address. (OK to use clinic address to maintain confidentiality).
REQUIRED 4.	Print the patient city, state, zip. (OK to use clinic city, state, zip to maintain confidentiality.) Please use the county of the patient's residence for surveillance purposes.
REQUIRED 5.	Provide the patient's Date Of Birth (DOB).
6.	Provide the patient's current age.
REQUIRED 7.	Check the appropriate gender.
8.	Indicate the patient's ethnicity, realizing that more than one may apply.
9.	Indicate the patient's race, realizing that more than one may apply.
10.	Provide the patient's medical record number.
11.	Provide the submitter specimen ID number.
12.	Pre-printed clinic information.
13.	Check the box as appropriate and print name(s) and address(es) in area provided above.
REQUIRED 14.	Print the name of the ordering provider.
REQUIRED 15.	Provide the ordering provider's NPI number.
REQUIRED 16.	Indicate appropriate insurance information. Please provide front and back copies of all insurance card(s).
17.	Check the box if the patient has Medicare. Please contact the laboratory when Medicare patient appointments are made so that an advanced beneficiary notice can be sent.
REQUIRED 18.	Check the appropriate billing box. Document if the family planning patient has no other method of payment and indicate any applicable funding.
19.	The patient's signature is **required** in order to bill private insurance. If the patient signature is on file in the clinic, please indicate appropriately.
REQUIRED 20.	Provide the appropriate ICD-10 code(s) to indicate medical necessity for the tests ordered.
REQUIRED 21.	Write the Date of Service (DOS) or Date of Collection.
22.	Document time of collection, if appropriate. (Not required for cytology)

Provide and document clinical history, specimen source, LMP, and test order as appropriate