$\supset [$				OVTOLOGY LAD		.,			/
	Date }	BA	RNES JEWISH Hospital		CORATORY REQUISITION tories • St. Louis, Missouri 6311			PHONE: (314) FAX: (314)	
	AC	COUNT INFORMAT	BIC HealthCare	 	,		MO DAY YR		
$\supset \frac{1}{2}$	NAME			PATIENT'S ADDRESS	CITY	STATE	ZIP	PHONE	
	ADDRESS			REFERENCE #		DIAGNOSIS	REQU	JIRE	
$\mid C$	CITY PHONE	STATE	ZIP	NAME OF RESPONSIBLE PAR	NSHIP TO RESPONSIBLE PARTY RTY (IF DIFFERENT FROM PATIENT)		2-SPOUSE RITY (INSURED SS#):	3-CHILD 4-	
) 	ORDERING MD / SUBMITTING BILL TO:	PHYSICIAN		ADDRESS OF RESPONSIBLE OF CITY	PARTY STATI	APT#		DA [*] MO	TE OF BIRTH DAY YR
! !	□ACCOUNT □	PATIENT/INSURANCE	ALTERNATE	MEDICAID#	STATE MEDICARE # (INCLUDE PREFIX/SU	FFIX)	□ PRIMARY	MEDICARE RETIREMEN	NT OR DISABILITY
)	SEND ADDITIONAL COPY OF REP	ORT TO:		INSURANCE COMPANY N	NAME	PLAN	☐ SECONDARY	DATE: CARRIER CODE	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	CLIENT NUMBER/PHYSICIAN NAM	ME PHONE/	FAX NUM.	SUBSCRIBER / MEMBER	#	LOCATION		GROUP#	
)	PHYSICIAN'S ADDRESS COLLECTION TIME	CITY, ST		SUBSCRIBER / MEMBER INSURANCE ADDRESS			PHYSICIAN'S PRO	VIDER#	
) 	: AM PM BJH REGISTRATION #	MO DAY		CITY		STATE	ZIP		
	REGISTERED }			EMPLOYER'S NAME OR	NUMBER				R'S COMP
)	<u> </u>	<u> </u>						☐ YES	S [NO
\mathbf{c}		CYTOLOGY GY	N(PAP SMEAR)		СҮТ	OLOGY: O	OTHER SOUR	CES	
ノ 	Source: (✔All That Apply) ☐ Vaginal	Type: (✔One) ☐ Screening	☐ 1 Slide	Liquid Based ☐ Liquid Pap	RESPIRATORY		GASTRIC:		
	☐ Ectocervix ☐ Endocervix ☐ EC Brush ☐ Fordemetrial	☐ Diagnostic	☐ 2 Slides ☐ 3 Slides ☐ Mars Than 3 slide	☐ Liquid Pap with HPV ☐ Liquid Pap/HPV Reflex Only**	☐ SPUTUM ☐ SPUTUM, POST BRON	CH	☐ BRUSH	IING NG	
	☐ Endometrial (Uterine Sample) ☐ Maturation Index (Requires Lateral Vaginal V	Vall Smear)	☐ More Than 3 slide	es	BRONCHIAL WASH		ESOPHAGEA		
"	Menstrual Status: LMI				☐ BRONCHIAL BRUSH _		_ UWASHI	NG	
)	Regular Irregu	,	☐ Post Partum	☐ Lactating	URINE		BILE DUC	FBRUSHING RACT MALIGNAN	ICY
-	☐ Perimenopausal	☐ Postmenopau	sal Post Hy	rsterectomy	BLADDER (VOID)		FISH TEST	ING OLE ASPIRATION	I SITE:
)		_		Present ☐ Yes ☐ No	☐ BLADDER (CATH) ☐ URETER				
1	Contraceptive Use? Other Hormonal therapy?	□ NO	☐ IUD ☐ Hormonal ☐ YES		RENAL PELVIS				
) ;	Abnormal bleeding? Previous atypical cytology?	□ NO * □ NO	□yes □yes		☐ FISH BLADDER CA			E EVALUATION COLE ASPIRATION	
i	Previous tumor? *	□NO	☐ YES		FLUIDS PERICARDIAL FLUID			PECIFY)	
)	Treatment History Infection History	NO	YES		☐ PERITONEAL FLUID _				
ノ ¦	Other Clinical Conditions	□NO	YES		☐ PLEURAL FLUID				
-	* IF YES: type if known				☐ CEREBROSPINAL FLU				
) <u>£</u> ¦	**HPV testing will be perform squamous cells of undetermi	ed as a reflex order on a ned significance (ASCU	nny liquid pap with a cyto S)	logic diagnosis of atypical	☐ PELVIC WASHING				
0/8(Cervicovaginal Cytology (Pa The Pap smear is a screening	test used to detect cervi	cal cancer and its precui	rsors; it is not a diagnostic proc	edure. False negative and false positive	results do occu	ır. Pap smear results	should be interprete	ed in the context
) 1221-19	of pertinent clinical information	and biopsy results as ir	dicated.						
). 12 <u>;</u>	CLINICAL DIAGNOSIS	S AND HISTORY:							
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ACCOUNT INFORMATION	Date }		RNES EWISH Hospital BIG HealthCare	PATIENT'S NAME (LAST)	tories • St. Louis, Missouri 6311	(MI) SEX	DATE OF BIRTH	PATIENT'S	(314) 362-5735
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NAME OF RESPONSE PROTITY EPPERSENT FROM PRIDAY SOCIAL SECURITY INSUREDS SS9				PATIENT'S RELATIO	ONSHIP TO RESPONSIBLE PARTY	1-SELF	2-SPOUSE	3-CHILE	4-OTHER
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Endometrical	Vaginal	☐ Screening	☐ 1 Slide	☐ Liquid Pap					
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Perimenopausal					☐ BAL				ING
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Cervix Present Yes No	Perimenopausal	☐ Postmenopau							RATION SITE:
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vious atypical cytology? * NO YES Since the street History Since and the street History Since at the street Histor	ntraceptive Use? er Hormonal therapy?	□NO	YES						
vious tumor? *	normal bleeding?	□ NO	☐YES						
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PLEURAL FLUID CEREBROSPINAL FLUID CEREBROSPINAL FLUID Dev testing will be performed as a reflex order on any liquid pap with a cytologic diagnosis of atypical amous cells of undetermined significance (ASCUS) Covaginal Cytology (Pap Smear) Disclaimer	atment History								
PV testing will be performed as a reflex order on any liquid pap with a cytologic diagnosis of atypical amous cells of undetermined significance (ASCUS) icovaginal Cytology (Pap Smear) Disclaimer	er Clinical Conditions								
amous cells of undetermined significance (ASCUS) icovaginal Cytology (Pap Smear) Disclaimer	YES: type if known								
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ACCOL	JNT INFORMATION			MO DAY		
NAME		PATIENT'S ADDRESS	CITY	STATE ZIP	PHONE	
ADDRESS		REFERENCE #		DIAGNOSIS		DED
		PATIENT'S RELATIO	NSHIP TO RESPONSIBLE PARTY	1-SELF 2-SPOUS	SE 3-CHIL	D 4-OTHER
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SEND ADDITIONAL COPY OF REPORT TO): 	INSURANCE COMPANY N	AME	PLAN	CARRIER	CODE
CLIENT NUMBER/PHYSICIAN NAME	PHONE/FAX NUM.	SUBSCRIBER / MEMBER :	ц	LOCATION	GROUP #	
PHYSICIAN'S ADDRESS	CITY, STATE, ZIP	SUBSCRIBER / MEMBER /	+	LOCATION	GROUP #	'
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BJH REGISTRATION #		ENDLOVER'S WITH	UMPED			TWODYEDIO COLID
REGISTERED }		EMPLOYER'S NAME OR N	IUMBER			WORKER'S COMP ☐ YES ☐ NO
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ource: (All That Apply)	TOLOGY GYN(PAP SMEAI	e) Liquid Based		OLOGY: OTHER SO		
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Endocervix	☐ 3 Slides ☐ More Than 3	Liquid Pap/HPV slides Reflex Only**	☐ SPUTUM, POST BRONG	CH. W	ASHING	
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enstrual Status: LMP (R	EQUIRED)		☐ BRONCHIAL BRUSH	W	ASHING	
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ntraceptive Use? er Hormonal therapy?	□ NO □ IUD □ Hormo □ NO □ YES □		☐ RENAL PELVIS			
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vious atypical cytology? * vious tumor? *	□ NO □ YES		FLUIDS PERICARDIAL FLUID		NEEDLE ASP ER (SPECIFY)	IRATION
atment History ction History	□NO □YES		☐ PERITONEAL FLUID			
er Clinical Conditions	□NO □YES		☐ PLEURAL FLUID			
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PV testing will be performed as amous cells of undetermined s	s a reflex order on any liquid pap with a significance (ASCUS)	cytologic diagnosis of atypical	LI FELVIO WASHING			
icovaginal Cytology (Pap Sn Pap smear is a screening test	near) Disclaimer used to detect cervical cancer and its pr	recursors; it is not a diagnostic proce	edure. False negative and false positive	results do occur. Pap smear	results should be	e interpreted in the context
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