Date }

BARNES-JEWISH Hospital
BJC HealthCare

CYTOLOGY LABORATORY REQUISITION

Department of Laboratories • St. Louis, Missouri 63110

PHONE: (314) 362-1470
FAX: (314) 362-5735

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

ORDERING MD / SUBMITTING PHYSICIAN

BILL TO:
☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ ALTERNATE

SEND ADDITIONAL COPY OF REPORT TO:

CLIENT NUMBER/PHYSICIAN NAME | PHONE/FAX NUM.

PHYSICIAN'S ADDRESS | CITY, STATE, ZIP

COLLECTION TIME : AM PM | COLLECTION DATE MO DAY YR

BJH REGISTRATION #

REGISTERED BY }

PATIENT

PATIENT'S NAME (LAST) | (FIRST) | (MI) | SEX | DATE OF BIRTH MO DAY YR | PATIENT'S SS #

PATIENT'S ADDRESS | CITY | STATE | ZIP | PHONE

REFERENCE # | DIAGNOSIS REQUIRED

RESP. PARTY

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ 1-SELF ☐ 2-SPOUSE ☐ 3-CHILD ☐ 4-OTHER

NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) | SOCIAL SECURITY (INSURED SS#):

ADDRESS OF RESPONSIBLE PARTY | APT # | DATE OF BIRTH MO DAY YR

CITY | STATE | ZIP

MEDICAID # | STATE | MEDICARE # (INCLUDE PREFIX/SUFFIX) | ☐ PRIMARY ☐ SECONDARY | MEDICARE RETIREMENT OR DISABILITY DATE:

INSURANCE

INSURANCE COMPANY NAME | PLAN | CARRIER CODE

SUBSCRIBER / MEMBER # | LOCATION | GROUP #

INSURANCE ADDRESS | PHYSICIAN'S PROVIDER #

CITY | STATE | ZIP

EMPLOYER'S NAME OR NUMBER | WORKER'S COMP ☐ YES ☐ NO

CYTOLOGY GYN(PAP SMEAR)

Source: (✔All That Apply)
- ☐ Vaginal
- ☐ Ectocervix
- ☐ Endocervix ☐ EC Brush
- ☐ Endometrial (Uterine Sample)
- ☐ Maturation Index (Requires Lateral Vaginal Wall Smear)

Type: (✔One)
- ☐ Screening
- ☐ Diagnostic

Slides: (✔One)
- ☐ 1 Slide
- ☐ 2 Slides
- ☐ 3 Slides
- ☐ More Than 3 slides

Liquid Based
- ☐ Liquid Pap
- ☐ Liquid Pap with HPV
- ☐ Liquid Pap/HPV Reflex Only**

Menstrual Status: LMP (REQUIRED)

☐ Regular ☐ Irregular ☐ Pregnant ☐ Post Partum ☐ Lactating

☐ Perimenopausal ☐ Postmenopausal ☐ Post Hysterectomy

☐ Cervix Present ☐ Yes ☐ No

Contraceptive Use?	☐ NO	☐ IUD	☐ Hormonal	☐ Other
Other Hormonal therapy?	☐ NO	☐ YES		
Abnormal bleeding?	☐ NO	☐ YES		
Previous atypical cytology? *	☐ NO	☐ YES		
Previous tumor? *	☐ NO	☐ YES		
Treatment History	☐ NO	☐ YES		
Infection History	☐ NO	☐ YES		
Other Clinical Conditions	☐ NO	☐ YES		

* IF YES: type if known

**HPV testing will be performed as a reflex order on any liquid pap with a cytologic diagnosis of atypical squamous cells of undetermined significance (ASCUS)

CYTOLOGY: OTHER SOURCES

RESPIRATORY
- ☐ SPUTUM
- ☐ SPUTUM, POST BRONCH.
- ☐ BRONCHIAL WASH
- ☐ BRONCHIAL BRUSH
- ☐ BAL

URINE
- ☐ BLADDER (VOID)
- ☐ BLADDER (CATH)
- ☐ URETER
- ☐ RENAL PELVIS
- ☐ FISH BLADDER CA

FLUIDS
- ☐ PERICARDIAL FLUID
- ☐ PERITONEAL FLUID
- ☐ PLEURAL FLUID
- ☐ CEREBROSPINAL FLUID
- ☐ PELVIC WASHING

GASTRIC:
- ☐ BRUSHING
- ☐ WASHING

ESOPHAGEAL
- ☐ BRUSHING
- ☐ WASHING

- ☐ BILE DUCT BRUSHING
- ☐ BILIARY TRACT MALIGNANCY FISH TESTING
- ☐ FINE NEEDLE ASPIRATION SITE:
- ☐ IMMEDIATE EVALUATION OF FINE NEEDLE ASPIRATION
- ☐ OTHER (SPECIFY)

Cervicovaginal Cytology (Pap Smear) Disclaimer
The Pap smear is a screening test used to detect cervical cancer and its precursors; it is not a diagnostic procedure. False negative and false positive results do occur. Pap smear results should be interpreted in the context of pertinent clinical information and biopsy results as indicated.

CLINICAL DIAGNOSIS AND HISTORY:

CYTOLOGY #

FORM NO. 1221-19 (08/01/11)

CLIA 26D0438672

CYTOLOGY

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PATIENT'S NAME (LAST) (FIRST) (MI) SEX DATE OF BIRTH MO DAY YR PATIENT'S SS #

PATIENT'S ADDRESS CITY STATE ZIP PHONE

REFERENCE # DIAGNOSIS REQUIRED

RESP. PARTY

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ 1-SELF ☐ 2-SPOUSE ☐ 3-CHILD ☐ 4-OTHER

NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) SOCIAL SECURITY (INSURED SS#):

ADDRESS OF RESPONSIBLE PARTY APT # DATE OF BIRTH MO DAY YR

CITY STATE ZIP

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INSURANCE ADDRESS PHYSICIAN'S PROVIDER #

CITY STATE ZIP

EMPLOYER'S NAME OR NUMBER WORKER'S COMP ☐ YES ☐ NO

CYTOLOGY GYN(PAP SMEAR)

Source: (✔All That Apply)
☐ Vaginal
☐ Ectocervix
☐ Endocervix ☐ EC Brush
☐ Endometrial (Uterine Sample)
☐ Maturation Index (Requires Lateral Vaginal Wall Smear)

Type: (✔One)
☐ Screening
☐ Diagnostic

Slides: (✔One)
☐ 1 Slide
☐ 2 Slides
☐ 3 Slides
☐ More Than 3 slides

Liquid Based
☐ Liquid Pap
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Menstrual Status: LMP (REQUIRED) ____

☐ Regular ☐ Irregular ☐ Pregnant ☐ Post Partum ☐ Lactating

☐ Perimenopausal ☐ Postmenopausal ☐ Post Hysterectomy

☐ Cervix Present ☐ Yes ☐ No

Contraceptive Use?	☐ NO	☐ IUD ☐ Hormonal ☐ Other	
Other Hormonal therapy?	☐ NO	☐ YES	____
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Previous tumor? *	☐ NO	☐ YES	____
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Other Clinical Conditions	☐ NO	☐ YES	____

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CYTOLOGY: OTHER SOURCES

RESPIRATORY
☐ SPUTUM
☐ SPUTUM, POST BRONCH.
☐ BRONCHIAL WASH ____
☐ BRONCHIAL BRUSH ____
☐ BAL ____

URINE
☐ BLADDER (VOID)
☐ BLADDER (CATH)
☐ URETER ____
☐ RENAL PELVIS ____
☐ FISH BLADDER CA

FLUIDS
☐ PERICARDIAL FLUID
☐ PERITONEAL FLUID ____
☐ PLEURAL FLUID ____
☐ CEREBROSPINAL FLUID
☐ PELVIC WASHING ____

GASTRIC:
☐ BRUSHING ____
☐ WASHING ____

ESOPHAGEAL
☐ BRUSHING ____
☐ WASHING ____

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☐ BILIARY TRACT MALIGNANCY FISH TESTING
☐ FINE NEEDLE ASPIRATION SITE: ____
☐ IMMEDIATE EVALUATION OF FINE NEEDLE ASPIRATION
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