

Required Information is Highlighted

CellNetix Pathology & Laboratories



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Patient Information				Specimen Information		
PATIENT LAST NAME	FIRST	M.I.	BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> F	GENDER ID <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> F	COLLECTION DATE	TIME
PATIENT D.O.B.	PATIENT SOCIAL SECURITY NUMBER	MRN	RACE/ETHNICITY		ICD-10 CODE(S)	
STREET ADDRESS				Referring MDs		
CITY	STATE	ZIP	PHONE			
Billing Information						
INSURANCE COMPANY NAME AND ADDRESS						
CITY	STATE	ZIP				
INSURANCE/SUBSCRIBER ID#	SUBSCRIBER NAME/RESPONSIBLE PARTY					
INSURANCE/GROUP#	MEDICARE#	<input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY				
SECONDARY	MEDICAID (coupon attached)					
<input type="checkbox"/> NO INSURANCE	WORKER'S COMP	<input type="checkbox"/> YES <input type="checkbox"/> NO				
INTERNAL USE ONLY						
CC report to: First and Last Names						

GYN CYTOLOGY

*Refer to ASCCP for Screening Guidelines and Recommendations

CYTOLOGY

Pap only

Pap, if ASCUS, Reflex to HPV

Pap, if ASCUS, Reflex to HPV, if POSITIVE, Reflex to HPV Genotype (16/18)

Pap, if Abnormal, Reflex to HPV

Pap, if Abnormal, Reflex to HPV, if POSITIVE, Reflex to HPV Genotype (16/18)

CYTOLOGY & HPV CO-TESTING

Pap with HPV

Pap with HPV, if POSITIVE, Reflex to HPV Genotype (16/18)

HPV PRIMARY

HPV, if POSITIVE, Reflex to Pap

HPV, if POSITIVE, Reflex to HPV Genotype (16/18) & Pap

ENDO/ECTO ENDOCX ECTOCERVIX CERVIX VAGINA

Check if tissue specimen is submitted simultaneously with Pap

CLINICAL HISTORY (check all that apply):

Pregnant Abnormal Bleeding Previous GYN Cone/LEEP History of Malignancy

Postpartum IUD Laser Therapy Chemotherapy

Postmenopausal DES Exposure Cervical Stump Radiation

Hormones Previous CIN/HPV Hysterectomy Other: _____

LMP Date: ___/___/___ Previous Pap Date: ___/___/___

Interpretation: Unsat. Negative ASCUS ASCH LSIL HSIL

Other: _____

HISTOLOGY (TISSUE SPECIMENS)

SPECIMEN SITE

A _____

B _____

C _____

D _____

Procedure/Clinical History/Other Information: _____

For breast specimens, time in formalin: _____

MOLECULAR

COLLECTION KIT

Aptima, Swab - Orange Label (use for all tests)
Source: Vaginal Anal (CT/GC only) Urethral Endocervical

Aptima, Swab - White Label (use for all tests)
Source: Urethral Endocervical

Aptima, Tube - Yellow Label (use for GC, CT or Trich testing only)
Source: Urine

CellSwab™ - Vaginitis Panel, Expanded TMA
Panel includes tests for Gardnerella vaginalis, Candida vaginitis (candida species C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis, Candida glabrata) and Trichomonas vaginalis

CellSwab™ - Vaginitis Panel, Expanded TMA + GC/CT
Panel includes all tests listed above, plus Chlamydia and Gonorrhea

Chlamydia/Gonorrhea Chlamydia/Gonorrhea/Trichomonas

Trichomonas

NON-GYN CYTOLOGY

Fine Needle Aspiration, Source: _____

Fluid, Source/Laterality: _____

Respiratory Cytology: BAL Brushing Washing Sputum
Source/Laterality: _____

Urine Cytology Reflex to Urovysion if Atypical
 Voided Catheterized Bladder Washing Barbotage

Anal-Rectal Cytology w/ HPV If ASCUS, Reflex HPV
 w/ HPV, Reflex HPV Geno (16/18) If ASCUS, Reflex HPV, Reflex HPV Geno (16/18)

Nipple Discharge Left Right

Herpes Tzanck Smear, Source: _____

Other: _____