☐ 88141 ☐ 88164
☐ 88142 ☐ 88175
☐ Unsatisfactory

***The Area Above This Line Is For Lab Use Only***


X·Cell Laboratories of Western New York, Inc.

20 Northpointe Parkway - Suite 100
Amherst, NY 14228
(716) 250-9235 Fax (716) 250-9242


Date Collected

Date Received (Lab Use)

Ordering Physician / Client

***PLEASE PRINT ALL INFORMATION CLEARLY***

| Patient Name | Last | First |
|---|---|---|
| Address | | |
| City State Zip | | |
| D.O.B. | | Sex | | Phone | |

Authorized Signature (Required)

***BILLING***

☐ Insurance ☐ Patient ☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

| ICD-10 Code (Mandatory) | ICD-10 Code | ICD-10 Code | ICD-10 Code |
|---|---|---|---|
| | | | |

COPY OF REPORT TO: **(FAX NUMBER(S) MUST BE PROVIDED)**

| NAME | FAX # |
|---|---|
| NAME | FAX # |

SECONDARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

Please label all specimens with the patient's full name. Provide patient's clinical history and other relevant information as appropriate. This is a requirement of the NYSDOH.

***GYN CYTOLOGY (PLEASE CHECK ALL THAT APPLY)***

**LMP**

**SOURCE**

☐ Cervical ☐ Endocervical
☐ Vaginal ☐ Ectocervical

☐ Post Menopausal ☐ IUD ☐ Abnormal GYN Exam ☐ Biopsy w/ Pap
☐ Total Hysterectomy ☐ Pregnant ☐ Abnormal Bleeding ☐ Clinical High Risk
☐ Sub-Total Hysterectomy ☐ Post Partum ☐ Previous GYN Malignancy ☐ Implanon
☐ Hormone Therapy ☐ DES: _____ ☐ Suspect Present Malignancy ☐ Depo Provera
☐ Birth Control Pills ☐ Vaginitis/Cervicitis ☐ Radiation or Chemotherapy

## GYN Cytology Pap Test

☐ **ThinPrep® Pap (0)** ☐ **SurePath® Pap (0)** ☐ **Conventional Pap**

## HPV Testing (Choose one)

☐ **High-Risk HPV regardless of Pap result with 16, 18/45 genotyping if HPV is positive (1)**

☐ **High-Risk HPV if Pap is ASCUS or above with 16, 18/45 genotyping if HPV is positive (2)**

☐ **High-Risk HPV and reflex 16, 18/45 genotyping if Pap is negative and HPV is positive (3)**

☐ **High-Risk HPV regardless of Pap result (4)**

☐ **High-Risk HPV if Pap is ASCUS or above (5)**

## Molecular Testing

☐ **Chlamydia** ☐ **Trichomonas**

☐ **Gonorrhea** ☐ **Mycomplasma genitalium**

* Please note: Chlamydia, Gonorrhea, and Trichomonas testing can be done off a Pap vial, Aptima swab, or Aptima urine. Mycoplasma genitalium testing can be done off an Aptima swab or Aptima urine.

## Panels

☐ **BD Affirm Swab (Candida, Gardnerella, Trichomonas)**

☐ **BD MAX Vaginal Swab (BV, Candida group, Candida glabrata, Candida krusei, Trichomonas vaginalis)**

## Additional Testing

☐ **Urinalysis** ☐ **Urine culture** ☐ **Group B Strep** ☐ **HSV** ☐ **Genital Culture Source:**

☐ **Other:**

Date of Previous Pap Smear: Reported As:

Date of Previous Biopsy: Reported As: