


Client Information	GYNECOLOGIC PATHOLOGY WCP Laboratories, Inc.		Specimen Accession#
	 2326 Millpark Drive Maryland Heights, MO 63043-3530 (314) 991-4313 • Fax (314) 991-4317		Results: <input type="checkbox"/> fax <input type="checkbox"/> phone <input type="checkbox"/> mail <input type="checkbox"/> online
	Submitting Physician		Date of Collection

PATIENT INFORMATION

Last Name		First Name		MI
Street Address		City, State		Zip Code
Patient Telephone #		Date of Birth (MM/DD/YYYY)		Patient Signature
SSN - -	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
BILL TO: <input type="checkbox"/> Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Medicare <input type="checkbox"/> Client <input type="checkbox"/> Medicaid <input type="checkbox"/> Other		Insurance Company & Address		Group # Patient Ins. ID #
PLEASE ATTACH INSURANCE CARD COPY		Last Name of Guarantor		First Name
I have read and understand the ABN on reverse side. Patient Initials _____		SSN / /	DOB / /	

TESTS REQUESTED

<input type="checkbox"/> ThinPrep Pap Smear <input type="checkbox"/> Gonorrhea/Chlamydia by PCR (ICD-9 _____) <input type="checkbox"/> Chlamydia by PCR (ICD-9 _____) <input type="checkbox"/> Gonorrhea by PCR (ICD-9 _____) <input type="checkbox"/> HPV DNA Testing on ASCUS Diagnosis <input type="checkbox"/> HPV DNA Testing (ICD-9 _____) <input type="checkbox"/> Conventional Pap Smear <input type="checkbox"/> Strep B Testing by PCR (ICD-9 _____) <input type="checkbox"/> Herpes Virus Testing by PCR (ICD-9 _____) <input type="checkbox"/> Biopsy (ICD-9 _____) <input type="checkbox"/> Other _____	<input type="checkbox"/> Screening Pap Smear NON-MEDICARE patient <p style="text-align: center;">OR</p> <input type="checkbox"/> Screening Pap Smear MEDICARE patient <input type="checkbox"/> Routine <input type="checkbox"/> High Risk <input type="checkbox"/> Low Risk w/o uterus or cervix <input type="checkbox"/> Diagnostic Pap Smear (ICD-9 _____) <input type="checkbox"/> Other (ICD-9 _____)
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p style="color: purple;">GYN CYTOLOGY SOURCE</p> <input type="checkbox"/> Cervical / Endocervical / Vaginal <input type="checkbox"/> Vaginal <input type="checkbox"/> Other: _____ <p style="color: purple;">GYN PATHOLOGY SOURCE</p> <input type="checkbox"/> Cervical <input type="checkbox"/> ECC <input type="checkbox"/> Cone Biopsy (including LEEP) <input type="checkbox"/> Endometrial <input type="checkbox"/> Vaginal <input type="checkbox"/> Polyp <input type="checkbox"/> Other: _____ <p style="color: purple;">NON-GYN CYTOLOGY</p> <input type="checkbox"/> Breast FNA <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Solid <input type="checkbox"/> Cyst <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Urine <input type="checkbox"/> Voided <input type="checkbox"/> Cath Other: _____	<p style="color: purple; text-align: center;">PLEASE SUPPLY THE FOLLOWING INFORMATION FOR COMPLETE EVALUATION AND CHECK ALL THAT APPLY.</p> LMP ____/____/____ Previous Pap ____/____/____ Previous DX _____ Previous BX ____/____/____ Previous DX ____/____/____ <input type="checkbox"/> Normal Exam (No prior abnl Pap) <input type="checkbox"/> Total Hyst <input type="checkbox"/> Supracervical Hyst <input type="checkbox"/> Pregnant <input type="checkbox"/> Post Partum <input type="checkbox"/> Post Menopausal <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> No Pap w/in 7 years <input type="checkbox"/> Abnormal Pap / Bx w/in 3 years (ASCUS, AGUS, or above) <input type="checkbox"/> Post menopausal Bleeding <input type="checkbox"/> Postcoital Bleeding <input type="checkbox"/> Gyn Malignancy; Hx/Rx <input type="checkbox"/> Pelvic Radiation <input type="checkbox"/> Abnormal Gyn Exam (e.g. HPV, Cervical lesion)
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

MICROBIOLOGY		Additional Comments:
Culture, Aerobic/Routine	Culture, Group B Streptococcus	
Culture, Anaerobic	Culture, Throat	
Gram Stain ONLY	MRSA Screen	
Culture, Fungus	Culture, Urine	
Smear Only, Fungus / KOH	Other _____	