



WOMEN'S HEALTH

PPS Use Only:	Tech Initial: _____	PPS Accessioning Department Only
	Result ID: _____	
	Date/Time: _____	

PATIENT INFORMATION			
Last Name		First Name	M.I.
Street Address		Apt. #	
City		State	Zip
Patient Phone Number		Patient Social Security Number	
Date of Birth / /	Age	Sex	Client ID #

CLIENT INFORMATION	
Treating Physician	UPIN #

BILLING / INSURANCE (or attach copy of insurance card - both sides)	
<input type="checkbox"/> Bill Patient Insurance (Attach copy of insurance card, both sides)	
<input type="checkbox"/> Bill Patient directly / No insurance	<input type="checkbox"/> Bill physician facility

ICD-10 CODE (Required)	
<input type="checkbox"/> Z01.419 Gyn exam without abnormal findings	
<input type="checkbox"/> Z01.411 Gyn exam with abnormal findings	
<input type="checkbox"/> Z39.2 Routine postpartum follow up	
<input type="checkbox"/> Z34.9 Encounter for normal pregnancy	
<input type="checkbox"/> Z11.3 Screening for infections	
<input type="checkbox"/> Z11.8 Screening for infections including parasites	
<input type="checkbox"/> Z11.51 Screening for HPV	
<input type="checkbox"/> Z12.4 Screening for cervical neoplasm	
<input type="checkbox"/> Z12.72 Screening for vaginal neoplasm	
<input type="checkbox"/> _____	

Physician's Signature X _____	
Send Duplicate of Report to:	
Name	_____
Address/Fax	_____

Collection Date _____

Collection Time _____

AGE BASED PANEL TESTING (ACOG/ASCCP Guidelines):	
<input type="checkbox"/> 21-24 years: CT/NG, pap with reflex to HR-HPV if pap is ASCUS	
<input type="checkbox"/> 25-29 years: pap with reflex to HR-HPV if pap is ASCUS	
<input type="checkbox"/> 30-65 years: pap plus HR-HPV (co-testing); reflex to genotyping if pap is negative and HR-HPV is positive	
<input type="checkbox"/> >65 years with history of CIN2 of greater: pap plus HR-HPV (co-testing); reflex to genotyping if pap is negative and HR-HPV is positive	

COLLECTION / HISTORY	
Site:	
<input type="checkbox"/> Cervix	
<input type="checkbox"/> Endocervix	
<input type="checkbox"/> Vagina	
Previous Pap Abnormality:	
<input type="checkbox"/> No	
<input type="checkbox"/> Yes: Date _____	
Diagnosis _____	
Treatment _____	
LMP: _____	
Contraceptive/Hormone Treatment:	
<input type="checkbox"/> IUD	
<input type="checkbox"/> Hormonal systemic	
<input type="checkbox"/> Hormonal local	
Status:	
<input type="checkbox"/> Pregnant	
<input type="checkbox"/> Post-partum	
<input type="checkbox"/> Post-menopausal	
<input type="checkbox"/> Abnormal bleeding	
<input type="checkbox"/> Post-hysterectomy:	
<input type="checkbox"/> Cervix absent	
<input type="checkbox"/> Cervix present	

INDIVIDUAL/ADD-ON TESTS:	
GYN Cytology:	
<input type="checkbox"/> Pap smear (ThinPrep)	
HPV Tests (Aptima):	
<input type="checkbox"/> High-risk HPV (HR-HPV)	
<input type="checkbox"/> HPV Genotyping 16, 18, 45	
<input type="checkbox"/> Reflex to HR-HPV if pap is ASCUS	
<input type="checkbox"/> Reflex to Genotyping 16, 18, 45 if HR-HPV is positive	
Infectious Disease Tests (Aptima):	
<input type="checkbox"/> Chlamydia/Gonorrhea (CT/NG)	
<input type="checkbox"/> <i>Trichomonas vaginalis</i>	
<input type="checkbox"/> Bacterial vaginosis panel (<i>Lactobacillus</i> species, <i>Gardnerella vaginalis</i> , <i>Atopobium vaginae</i>)	
<input type="checkbox"/> Vaginitis panel (<i>Candida</i> species, <i>Candida glabrata</i> , <i>Trichomonas vaginalis</i>)	
<input type="checkbox"/> Herpes simplex virus (HSV) 1 & 2	
<input type="checkbox"/> Group B Strep (GBS)	
<input type="checkbox"/> <i>Mycoplasma genitalium</i>	
<input type="checkbox"/> _____	
<input type="checkbox"/> _____	

NOTES:	