



PRECISION PATHOLOGY LABORATORY SEXUAL HEALTH REQUISITION

PPS Use Only:

Tech Initial: _____
Result ID: _____
Date/Time: _____

**PPS
Accessioning
Department
Only**

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	
Client Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Fax:	_____
Email:	_____
Treating Physician	UPIN #
Physician's Signature <input checked="" type="checkbox"/> _____	
Send Duplicate of Report to:	
Name	_____
Address/Fax	_____

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"/> _____	

PANEL TESTING:	
Age Based Panel Testing (ASCOG/ASCO 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	
Comprehensive Panels:	
<input type="checkbox"/> Women's Comprehensive Health Panel (2 Aptima Multitest swabs) Chlamydia/Gonorrhea, Trichomonas vaginalis, Extended bacterial vaginosis panel, Vaginitis panel, Herpes simplex virus 1&2, mycoplasma genitalium	
<input type="checkbox"/> Men's Comprehensive Health Panel (2 Aptima Multitest swabs) Chlamydia/Gonorrhea, Trichomonas vaginalis, Herpes simplex virus 1&2, mycoplasma genitalium	

INDIVIDUAL/ADD-ON TESTS:	
GYN Cytology:	
Pap smear (ThinPrep)	
HPV Tests:	
<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	
Other:	
<input type="checkbox"/> Chlamydia/Gonorrhea (ThinPrep/Aptima Multi/Aptima Unisex)	
<input type="checkbox"/> Trichomonas vaginalis (ThinPrep/Aptima Multi/Aptima Unisex/Urine)	
<input type="checkbox"/> Herpes Simplex 1&2 (Aptima Multi)	
<input type="checkbox"/> Mycoplasma genitalium (Aptima Multi/Aptima Unisex/Urine)	
<input type="checkbox"/> Extended bacterial vaginosis Panel (Aptima Multi)	
<input type="checkbox"/> Vaginitis panel (Aptima Multi)	
<input type="checkbox"/> Group B Strep (BD Swab)	
<input type="checkbox"/> _____	

Collection Date _____ Collection Time _____

COLLECTION / HISTORY		
Site: (Required)		
<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	

NOTES:	



SEXUAL HEALTH REQUISITION

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Treating Physician	UPIN #
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Physician's Signature	X _____
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<input type="checkbox"/>	Mycoplasma genitalium (<i>Aptima Multi/Aptima Unisex/Urine</i>)
<input type="checkbox"/>	Extended bacterial vaginosis Panel (<i>Aptima Multi</i>)
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