OHSU Health
Hospital & Clinics

GYNECOLOGIC CYTOLOGY DOWNTIME REQUISITION

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTH DATE SEX

Stamp Patient Card Here

*Requesting Provider	*I.D. Number	*Beeper / Extension	*RecLoc	Cytology Accession No
Resident / Fellow	Resident I.D. #			

FEDERAL REGULATIONS REQUIRE ALL *BOLD ITEMS MUST BE COMPLETED OR THE SPECIMEN WILL NOT BE ACCEPTED.

***Collection Date:** _____

***Collection Site:**

_____ Cervix

_____ Vagina

_____ Cervix and Vagina

_____ Other:_____

***Clinic Must Provide**

ICD-10 Code _____

Date of onset if not screening _____

Date of similar symptom _____

If pregnant, estimated due date _____

***Reason for Examination (check one):**

* ____Diagnostic Pap (patient with previous abnormal Pap smear or signs & symptoms suggestive of a gynecological disorder or history of cancer of the uterus, cervix, vagina)
* ____Screening Pap (Low risk patient)
* ____Screening Pap (High risk patient)

HPV Testing

* ____Perform high-risk HPV testing.
* Perform high-risk HPV testing only following ASC-US or LSIL interpretation.

* **Date LMP:**_____

_____ Pregnant _____ Weeks _____ IUD
_____Postpartum _____Weeks _____ Hormone Replacement Therapy
_____Postmenopausal _____Years _____ Other
_____BCP

***Previous Diagnoses (check all that apply):**

_____ Within Normal Limits
_____Low Grade SIL (includes condyloma / HPV / CIN-I)
_____High Grade SIL (includes CIN-II, CIN-III, CIS
_____Other:_____

Previous therapy (please circle)
conization colposcopy & biopsy LEEP
radiotherapy cryotherapy oophorectomy hysterectomy
chemotherapy other:_____

Results will be immediately available to the patient unless you mark the box below:
☐ Do not release (I reasonably believe that an Information Blocking exception applies)

Comments / Requests: _____