acla
ANATOMIC & CLINICAL LABORATORY ASSOCIATES, P.C.
2010 Church Street, Suite 615 • Nashville, TN 37203
(615) 284-7956 Fax (615) 284-4368

PAP REQUEST

ACCESSION #

DATE RECEIVED
THIS BOX IS FOR ACLA USE.

ADVANCE BENEFICIARY NOTICE (ABN) IS REQUIRED FOR ALL MEDICARE PATIENTS.

Medicare

- Medicare Screening Pap (V76.2) ☐
- Medicare High Risk Pap (V15.89) ☐
- Medicare Diagnostic Pap
  MUST provide ICD-9 Code: ____________

Other Carriers

- Annual Gynecological Exam (V72.31) ☐
- Diagnostic Pap
  MUST provide ICD-9 Code: ____________

ICD-9 (DIAGNOSIS CODES) MUST BE PROVIDED FOR PAP TEST AND REFERENCE TESTING.

REFERENCE TESTING

- ☐ High Risk HPV (Diagnostic ICD-9) ____________
- ☐ Age >= 30 High Risk HPV (VICD-9) ____________
- ☐ High Risk Only (No Pap) ____________
- ☐ Chlamydia ____________
- ☐ Gonorrhea ____________
- ☐ HSV (1 and 2) ____________
- ☐ Strep B ____________
- ☐ Cystic Fibrosis* ____________

Please complete and sign patient consent form

PATIENT NAME: ______________________________

PLEASE COMPLETE ALL SHADED AREAS OF THIS FORM.

Date of Smear: ____________________ ThinPrep: ☐ OR # Traditional Slides: ______

1st Day LMP: ____________________ Site: VAG ☐ CX ☐ ENCX ☐

CLINICAL HISTORY:

- _____ No Abnormalities
- _____ Amenorrhea
- _____ DES Exposure
- _____ Abnormal Bleeding
- _____ Abnormal Discharge
- _____ Oral Contraceptive _____ Patch _____ Ring
- _____ IUD _____ Depo Provera
- _____ HX of ASCUS/AGUS
- _____ HX of Dysplasia
- _____ CIN _____ VIN _____ VAIN
- _____ HX of CA ____________________
- _____ Chemo TX _____ Radiation TX
- _____ Leetz _____ Cone _____ Laser
- _____ Colpo _____ Cryo
- _____ Family HX of CA
- _____ Hysterectomy - Total
- _____ Hysterectomy - Supra Cervical
- _____ Post Menopausal
- _____ Post Menopausal Bleeding
- _____ Hormone Replacement TX
- _____ Pregnant _________ Weeks
- _____ Post Partum _________ Weeks
- _____ Breast Feeding

Previous Pap Date: ____________________

ACLA #: ____________________

Previous Pap performed at another lab: ______

COMMENTS/OTHER CLINICAL HISTORY:

____

____

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