ANATOMIC & CLINICAL
LABORATORY ASSOCIATES, P.C.

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PAP REQUEST

ACCESSION # ______

DATE RECEIVED ______

THIS BOX IS FOR ACLA USE.

PATIENT INFORMATION

OFFICE I.D. # ______

NAME LAST ______ FIRST ______

MAILING ADDRESS ______ APT. # ______

CITY ______ STATE ______ ZIP ______

HOME PHONE ______ OFFICE PHONE ______

INSURANCE INFORMATION:

- ☐ **Copy of insurance card attached (front and back).**
- ☐ **Copy of patient's registration or data sheet attached.**
- ☐ **Self-pay/No insurance.**

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

- ☐ HPV DNA ______
- ☐ Chlamydia ______
- ☐ Gonorrhea ______
- ☐ HSV (1 and 2) ______
- ☐ Strep B ______
- ☐ Cystic Fibrosis * ______

***Additional Info Required for CF Test:**

Racial/Ethnic Background: ______

Does the patient have a positive family history of CF? ☐ Yes ☐ No ☐ Unknown

If Yes, please list known mutations:

COMMENTS/OTHER CLINICAL HISTORY:

______

THIS BOX IS FOR ACLA USE.

______

PLEASE COMPLETE ALL SHADED AREAS OF THIS FORM

Date of Smear: ______

1st Day LMP: ______

ThinPrep: ☐ OR # Traditional Slides: ______

Site: VAG ☐ CX ☐ ENCX ☐

SS#: ______

DOB: ______

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
- ____ Hysterectomy - Total
- ____ Hysterectomy - Supra Cervical
- ____ Post Menopausal
- ____ Post Menopausal Bleeding
- ____ Hormone Replacement TX
- ____ Family HX of CA
- ____ Pregnant ______ Weeks
- ____ Post Partum ______ Weeks
- ____ Breast Feeding

Previous Pap Date: ______

ACLA #: ______

Previous Pap performed at another lab: ______