MediPath
PATHOLOGY SERVICES
4665 Ponce De Leon Blvd., Coral Gables, FL 33146
Telephone 786-464-0749 • Fax 786-953-5342

GYNECOLOGIC REQUISITION

G017951

PATIENT INFORMATION			CLIENT INFORMATION		
LAST NAME	FIRST NAME	MI			
DATE OF BIRTH	MRN/PT.CHART#	SEX ☐ Male ☐ Female			
STREET ADDRESS					
CITY	STATE	ZIP	DATE COLLECTED	TIME COLLECTED	☐ AM ☐ PM
HOME PHONE #	WORK PHONE #		ICD-10 CODE(S):		

INSURANCE INFORMATION

For Medicare patients please complete an ABN "Advanced Beneficiary Notice", see reverse

PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
STREET ADDRESS	CITY / STATE / ZIP	STREET ADDRESS	CITY / STATE / ZIP
GROUP NUMBER	POLICY NUMBER	GROUP NUMBER	POLICY NUMBER
NAME OF POLICY HOLDER		NAME OF POLICY HOLDER	

CLINICAL INFORMATION

Last Menstrual Period: ___/___/_____ ☐ AUB (☐ Menorrhagia ☐ Metrorrhagia ☐ Both) ☐ Postmenopausal: date: ___/___/_____
☐ Lactating/Postpartum ☐ Pregnant Weeks: _____ ☐ Hormone Therapy (☐ in use: Contraceptives/Depo/Norplant/Other) ☐ IUD ☐ DES
☐ Clinically Apparent Infection ☐ Suspicious lesion ☐ History of Malignancy: Radiation or Chemo (circle if apply)
☐ Abnormal GYN PAP test date: ___/___/_____ Treatment: _____ ☐ Surgical History: Type: _____ Date: ___/___/_____
☐ 1st degree family history of malignancy (before 50 years of age in family member): _____

CURRENT/RELEVANT CLINICAL INFORMATION: ☐ Clinically Apparent Infection ☐ Mass, features: _____

SOURCE

SOURCE(S): ☐ Perineum ☐ Vulva ☐ Vagina ☐ Vaginal Cuff ☐ Cervix ☐ Endocervix ☐ Ectocervix ☐ Uterus/Endometrium ☐ POCs ☐ Fallopian Tube ☐ Ovary ☐ Skin ☐ Soft Tissue ☐ Abdomen/Peritoneal/Inguinal ☐ Foreign body ☐ Other: _____

GYN-CYTOLOGY

☐ 201-PAP ☐ 202-PAP + HPV ☐ 203-PAP + HPV Reflex to HPV Geno ☐ 204-PAP Reflex HPV if ASCUS ☐ 205-PAP Reflex HPV if ASCUS, Reflex HPV Geno ☐ 206-PAP Reflex HPV if ABNORMAL ☐ 207-PAP Reflex HPV if ABNORMAL, Reflex HPV Geno ☐ 211-PAP (Non-Imaged)

MOLECULAR MICROBIOLOGY

GYN: ☐ CT (Chlamydia) ☐ CT/NG (Chlamydia/N. Gonorrhea) ☐ BV (Bacterial Vaginosis) ☐ CV (Candida) ☐ CV/TV (Candida/Trichomonas) ☐ TV (Trichomonas) ☐ HSV 1 & 2 (Herpes Simplex Virus 1 & 2) ☐ CT/NG (Chlamydia/N. Gonorrhea) *on* ***urine*** *yellow Aptima* ☐ Group B Streptococcal (GBS) ☐ Mycoplasma Genitalium (Mgen) ☐ Trichomonas *on* ***urine*** *yellow Aptima*

HISTOLOGY & NON-GYN CYTOLOGY

PROCEDURE: ☐ Core Biopsy ☐ Punch biops ☐ Incisional biopsy ☐ Excision ☐ Brushing ☐ Curetting ☐ Removal/Extraction/Passage ☐ Ectomy ☐ Piecemeal Ectomy ☐ Ligation ☐ Herniorrhaphy ☐ LEEP/Conization ☐ Ligation ☐ Hysterectomy ☐ Oophorectomy ☐ Salpingectomy ☐ Fine Needle Aspiration (FNA) ☐ Fluid aspiration

Laterality	Source	Oriented with Sutures	Laterality	Source	Oriented with Sutures
A. ☐ Right ☐ Left		☐	**C.** ☐ Right ☐ Left		☐
B. ☐ Right ☐ Left		☐	**D.** ☐ Right ☐ Left		☐
Others:			Others:		
Others:			Others:		

Note: when ordering tests for which Medicare reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient.

Physician Signature: _____ **Date:** _____

A G017951		**B** G017951		**C** G017951		**D** G017951	
Patient Name	D.O.B.	Patient Name	D.O.B.	Patient Name	D.O.B.	Patient Name	D.O.B.
E G017951		**F** G017951		**G** G017951		**H** G017951	
Patient Name	D.O.B.	Patient Name	D.O.B.	Patient Name	D.O.B.	Patient Name	D.O.B.

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