

Alomere Health Department of Pathology

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cytology # _____

Patient Name _____
Social Security # _____
Address _____
DOB: _____ AGE: _____

COLLECTION DATE _____

PHYSICIAN _____

FACILITY NAME _____

PATIENT STATUS: IP OP CLINIC

INSURANCE CO. _____

INSURANCE # _____

GROUP # _____

MEDICAID/MEDICARE # _____

*PLEASE SEND COPY OF INSURANCE CARD OR FACE SHEET

LMP _____

PREGNANT YES _____ NO _____

HORMONE THERAPY YES _____ NO _____

ABNORMAL BLEEDING YES _____ NO _____

PREVIOUS PAP YES _____ NO _____

RESULTS: NEG _____ ABNORMAL _____

SPECIMEN SOURCE:

PAP SMEAR (Thin Prep)

PAP SMEAR (Conventional)

NONGYNECOLOGICAL (Specify Site) _____

PERTINENT CLINICAL DATA _____

Check one of the following:

SCREENING (low risk) Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89

SCREENING (high risk) Z72.51, Z12.52, Z12.53, Z77.22, Z77.9, Z91.89, Z92.89

DIAGNOSTIC
(Signs, Symptoms, History of gyn disease)

ICD.10 DX Code: _____

ABN ON FILE: YES NO

CYTOLOGY EXAM REQUEST

American Solutions for Business (05/18)