Wisconsin State Laboratory of Hygiene
THE UNIVERSITY of WISCONSIN MADISON

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(PLEASE PRINT USING CAPITALS FIELDS IN RED ARE REQUIRED)

(1) Patient Last Name | First Name | Middle Name

(2) Name Change – Former Last Name

(3) Patient Address

(4) City | State | Zip | County of Patient's Residence

(5) Date of Birth | (6) Age | (7) ☐ Female ☐ Male

(8) Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

(9) ☐ Amer Indian ☐ Asian ☐ Black/African Amer ☐ Pacific Islander ☐ White ☐ Other_____

(10) Chart #/Patient ID Number

(11) Social Security Number if patient has private commercial insurance.

(13) ADDITIONAL REPORT COPIES NEEDED?
Please check this box ☐ **AND**
Enter the clinicians name and address on the back of this form.

(14) Ordering Provider

(15) NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

(16) Attached copies of front and back of insurance card(s)? ☐

(17) HAVE YOU PRESENTED AN ADVANCED BENEFICIARY NOTICE (ABN) TO YOUR PATIENT?
☐ YES: PLEASE SUBMIT A COPY. ☐ NO: CLINIC MAY BE RESPONSIBLE FOR MEDICARE DENIAL, PLEASE CALL THE LAB.

(18) BILLING INFORMATION ☐ PRIVATE INSURANCE (please send both sides of card) ☐ BILL CLINIC ☐ NO INSURANCE
☐ MEDICAID #_____ PLEASE SPECIFY MA TYPE: ☐ TE ☐ FPOS ☐ BadgerCare ☐ OTHER _____
☐ WWWP#_____ ☐ MEDICARE # _____(need ABN, see #17)

(19) I authorize WSLH to release my personal information to a Third Party Payer For purposes of billing. I understand that information may be sent from the Third Party to the address of the policy holder.
Patient Signature: _____ Date: _____

20) MEDICAL NECESSITY: Please write in the most appropriate code for Pap, HPV, and/or Tissue collection below.
(A) ☐ ICD-9 Code **V25.9** **CHECK (A) FOR FAMILY PLANNING CONFIDENTIALITY** (B) ICD9 _____ (C) ICD9 _____ (D) ICD9 _____ (E) ICD9 _____

(21) Date of Collection | (22) Time of Collection
Not applicable for GYN, HPV, HISTO

CONTRACEPTION & HORMONE THERAPY

☐ Oral Contraception (L40) ☐ Depo-Provera (L510) ☐ HRT (L503)
☐ IUD: ☐ Mirena (L52) or ☐ Paragard (L52) ☐ Condoms
☐ Vaginal Ring (L43) ☐ Other_____
Currently Pregnant? ☐ No ☐ Yes, How Many Weeks? _____
Post Partum? ☐ No ☐ Yes, How Many Weeks? _____
Gravida_____Para_____Ab_____

CURRENT CLINICAL FINDINGS

☐ Abnormal Bleeding (L70) ☐ Chlamydia (L78) / ☐ GC (L90) ☐ HSV (L92)
☐ Bacterial Vaginitis (L74) ☐ Friable Cervix (L507) ☐ Trich (L114)
☐ Candida ☐ HPV (L500)
☐ Cervicitis (L76) ☐ Hysterectomy (L25) ☐ BSO

OTHER CLINICAL HISTORY (PLEASE SPECIFY FOR GYN, HISTOLOGY, NGYN & FNA):

☐ **COLP TODAY**

HISTORY / PROCEDURES

	Date / Result		Date / Result
☐ Biopsy (592)		☐ D&C (22)	
☐ ECC (869)		☐ LEEP (504)	
☐ Colp (16)		☐ Cone (18)	

☐ Other (Please Specify):

PREVIOUS PAP/HPV TEST: ☐ First Pap ☐ State Lab ☐ Elsewhere
☐ Normal ☐ Abnormal Result: _____
☐ HPV NEG ☐ HPV NEG Date: _____

GYNECOLOGIC LAB TEST ORDERS

LMP: ____/_____/_____ ☐ UNKNOWN ☐ POST MENOPAUSAL
☐ Screening Pap Test (Routine Visit, Low Risk for Cervical Cancer)
☐ Diagnostic Pap Test (Previous Cervical Abnormalities, High Risk for Cervical Cancer)

PAP TEST ☐ Conventional ☐ Liquid Base

SOURCE:
☐ Cervical/Endocervical
☐ Vaginal ☐ Vulva
☐ Endocervical ONLY
☐ Other_____

HPV TEST
☐ HPV Regardless of DX (=/> 30) ICD9: _____
☐ HPV for Follow Up of ABN ICD9: _____
☐ Reflex HPV if ASCUS (=/> 21)
☐ HPV ONLY—NO PAP ICD9: _____ ☐ Cervical/Vaginal ☐ Anal
☐ NO REFLEX HPV

HISTOLOGY LAB TEST ORDERS

(PLEASE COMPLETE PROCEDURE, SOURCE, SPECIMENS SUBMITTED)

PROCEDURE / SOURCE
☐ Colposcopy
☐ Endocervical Curetting (ECC)
☐ Endocervical Sample (brush collection)
☐ Biopsy
☐ Ectocervical ☐ Endocervical
☐ Vaginal ☐ Vulva
☐ Uterus ☐ D&C
☐ Other:
☐ Cone Biopsy
☐ LEEP

SPECIMEN(S) SUBMITTED
A. _____
B. _____
C. _____
D. _____
E. _____
F. _____

NON-GYNECOLOGIC & FINE NEEDLE ASPIRATION LAB TEST ORDERS

☐ Bladder Wash ☐ Voided Urine ☐ Catheterized Urine
☐ Breast Discharge ☐ R ☐ L
☐ Other: _____

FINE NEEDLE ASPIRATION
☐ Breast ☐ R ☐ L | ☐ Neck Mass ☐ R ☐ L
☐ Salivary Gland ☐ R ☐ L | ☐ Thyroid ☐ R ☐ L
☐ FNA Other: _____