

GYNECOLOGIC CONSULTATION REQUEST

INFORMATION IN SHADED AREAS IS REQUIRED

500 Martha Jefferson Drive • Charlottesville, VA 22911 • (434) 654-7775 • Fax (434) 654-7776

R. Hunt MacMillan III, M.D., Laboratory Medical Director

Financial #

Patient Last Name		First Name		MI	MR No.	Accession No.	
Address			City	State	Zip	DX/ICD9	Chart No.
Referring Physician				Group/Practice		Patient's Phone #	
Date Collected	DOB	Patient SS #			LMP Date:	<input type="checkbox"/> Birth Control Pill <input type="checkbox"/> IUD <input type="checkbox"/> Other Birth Control:	
BILLING/INSURANCE (OR ATTACH COPY OF INSURANCE CARD - BOTH SIDES)							
<i>*NOTE: Separate signed ABN form required for Medicare patients</i>							
Bill	<input type="checkbox"/> Insurance <input type="checkbox"/> Medicare* <input type="checkbox"/> Physician <input type="checkbox"/> Patient <input type="checkbox"/> Medicaid <input type="checkbox"/> Workers Comp <input type="checkbox"/> Other			<input type="checkbox"/> Secondary Insurance Information Attached		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Emergency Room
Insurance Company				Contract No./Policy No.		Group No.	
Insurance Company Address				City	State	Zip	Insurance Company's Phone No.
Responsible Party (If different from patient/Policyholder's Name)						Relationship to Patient	
Responsible Party's Address						City	State Zip
						Responsible Party's Phone No.	

SPECIMEN			
Source <input type="checkbox"/> Cervical <input type="checkbox"/> Vaginal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Other GYN _____	Device <input type="checkbox"/> Spatula <input type="checkbox"/> Brush <input type="checkbox"/> Rover Brush		
Reason for Visit <input type="checkbox"/> Routine Visit/Exam <input type="checkbox"/> Follow-up/Abnormal Pap Patient History <input type="checkbox"/> Pregnant <input type="checkbox"/> Rad/Chemotherapy <input type="checkbox"/> Postpartum <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Hormone Use <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Prev. Gyn Abnormality/Dysplasia <input type="checkbox"/> GYN Malignancy	Examinations Requested <i>Specimen type:</i> <input type="checkbox"/> SurePath liquid specimen: <input type="checkbox"/> Pap Test -OR- <input type="checkbox"/> Other Testing ONLY <small>(NO Pap test)</small> <i>with these additional test(s):</i> <input type="checkbox"/> Reflex HPV (on ASCUS only) <input type="checkbox"/> HPV Test <input type="checkbox"/> HPV (regardless of Pap diagnosis) <input type="checkbox"/> Chlamydia/N. gonorrhea <input type="checkbox"/> Chlamydia/N.gonorrhea <input type="checkbox"/> HSV I & II by PCR <input type="checkbox"/> HSV I & II by PCR OR ----- <input type="checkbox"/> Conventional Pap Smear Slide		
<table border="1"> <tr> <td> Prev. Pap <input type="checkbox"/> Negative Abnormal <input type="checkbox"/> ASCUS/AGUS/SIL <input type="checkbox"/> Malignancy <input type="checkbox"/> Other _____ </td> <td> Prev. Cerv./Vag. Bx Results <input type="checkbox"/> Negative <input type="checkbox"/> Abnormal: </td> </tr> </table>	Prev. Pap <input type="checkbox"/> Negative Abnormal <input type="checkbox"/> ASCUS/AGUS/SIL <input type="checkbox"/> Malignancy <input type="checkbox"/> Other _____	Prev. Cerv./Vag. Bx Results <input type="checkbox"/> Negative <input type="checkbox"/> Abnormal:	Previous HPV Test <input type="checkbox"/> HPV not detected <input type="checkbox"/> HPV detected
Prev. Pap <input type="checkbox"/> Negative Abnormal <input type="checkbox"/> ASCUS/AGUS/SIL <input type="checkbox"/> Malignancy <input type="checkbox"/> Other _____	Prev. Cerv./Vag. Bx Results <input type="checkbox"/> Negative <input type="checkbox"/> Abnormal:		

PT NAME _____	PT NAME _____
DOB _____	DOB _____
PT NAME _____	PT NAME _____
DOB _____	DOB _____

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