

160 Allen Street, Rutland, VT 05701 | www.RRMC.org | 802.747.1771

PATIENT NAME (LAST) <input type="checkbox"/> Female <input type="checkbox"/> Male	(FIRST) (INIT.) DOB	REQUIRED CLINICAL INFORMATION FOR PAP TEST AND HPV PRIMARY SCREEN ONLY Specimen Date/Time: _____ LMP: _____ SAMPLE: <input type="checkbox"/> THIN PREP <input type="checkbox"/> CONVENTIONAL SMEAR (# OF SLIDES ____) SOURCE: <input type="checkbox"/> VAGINAL <input type="checkbox"/> CERVICAL <input type="checkbox"/> ENDOCERVICAL BIRTH CONTROL PILLS: <input type="checkbox"/> YES <input type="checkbox"/> NO IUD: <input type="checkbox"/> YES <input type="checkbox"/> NO PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO POSTPARTUM: <input type="checkbox"/> YES <input type="checkbox"/> NO HORMONE THERAPY: <input type="checkbox"/> YES <input type="checkbox"/> NO CHEMO/RADIATION: <input type="checkbox"/> YES <input type="checkbox"/> NO PREVIOUS PAP IN LAST 7 YEARS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DATE ____/____ PREVIOUS ABNORMAL PAP or ABNORMAL SURGICAL HISTORY IN LAST 3 YEARS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES TO ABOVE, PLEASE PROVIDE PREVIOUS ABNORMAL DATE AND DIAGNOSIS: OTHER CLINICAL HISTORY/COMMENTS:
PRINT PROVIDER NAME (LAST, FIRST) PROVIDER SIGNATURE DATE/TIME		OTHER CLINICAL HISTORY/COMMENTS:
HPV Testing Options		
Choose the HPV High Risk (HR) DNA testing based on the Pap Test Diagnosis: (See Back for Order Conditions) <input type="checkbox"/> Co-testing ¹ <input type="checkbox"/> Co-Testing Reflex to Genotype ² <input type="checkbox"/> If ASC /LSIL Pap Diagnosis ³ <input type="checkbox"/> No HPV Testing Requested <input type="checkbox"/> HPV DNA Primary Screen w/ Reflex to PAP test ⁴		
TESTING PRIORITY <input type="checkbox"/> Routine <input type="checkbox"/> STAT		
PROVIDERS ARE REQUIRED TO COMPLETE THE FOLLOWING SECTIONS: The provider must determine if the Pap Test is submitted as a SCREENING or DIAGNOSTIC laboratory test. Indicate Diagnosis, Sign or Symptom for Screening or Diagnostic Pap Test. An appropriate diagnosis, sign or symptom must be submitted for both Screening and Diagnostic Pap Tests. To indicate medical necessity, the diagnosis, sign or symptom must correspond to your medical record.		
<input type="checkbox"/> Routine Screening Pap Test <input type="checkbox"/> Routine Cervical Pap and Lab Report <input type="checkbox"/> Other _____	<input type="checkbox"/> High Risk Screening Pap Test <input type="checkbox"/> Routine Cervical Pap and Other history presenting hazard to health <input type="checkbox"/> High risk sexual behavior <input type="checkbox"/> Asymptomatic HIV infection status <input type="checkbox"/> Other _____	<input type="checkbox"/> Diagnostic Pap Test <input type="checkbox"/> Previous Abnormal Pap test <input type="checkbox"/> Post-Menopausal Bleeding <input type="checkbox"/> Positive Cervical High Risk HPV DNA Test <input type="checkbox"/> Dysplasia of Cervix <input type="checkbox"/> ASCUS (Pap test of cervix with atypical squamous cells) <input type="checkbox"/> Unsatisfactory Cervical Cytology Test <input type="checkbox"/> Other _____

Molecular Testing Options		
<input type="checkbox"/> GTY Probe (Vaginal Pathogens: Gardnerella, Trichomonas, Candida)	<input type="checkbox"/> Affirm	Diagnosis (Signs and Symptoms):

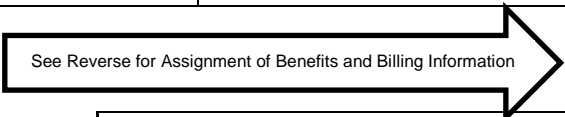
PLEASE COMPLETE PATIENT INSURANCE INFORMATION OR ATTACH TO AVOID DIRECT PATIENT BILLING

PATIENT STREET ADDRESS		MAIDEN / PREVIOUS NAME	
CITY / STATE / ZIP		PHONE NO.	
PRIMARY INSURANCE COMPANY NAME		STREET ADDRESS	
CITY		STATE	ZIP
POLICY NO.		GROUP NO.	
SUBSCRIBER	DOB OF SUBSCRIBER IF DIFFERENT FROM PATIENT	SUBSCRIBER RELATIONSHIP TO PATIENT	



FOR RRMC USE ONLY
Lab Specimen No.
Rec'vd Date:

Requisition QC Check
Phlebotomist _____
Processor _____



PATIENT LABEL

HPV Testing Options and Reflex Orders: Additional Testing will be performed if certain criteria are met.

- 1 HPV HR DNA Co-Testing
Providers will receive a HPV High Risk (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66 and 68) panel result regardless of the Pap test diagnosis.
- 2 HPV HR DNA Co-Testing Reflex to Genotype
Providers will receive a HPV High Risk (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66 and 68) panel result regardless of the Pap test diagnosis.
If the Pap test is Negative and the HR Panel is positive, genotyping for HPV 16, HPV 18 and Other High Risk HPV types (31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68) will be performed at an additional charge.
- 3 HPV HR DNA if ASC / LSIL PAP DIAGNOSIS
Providers will receive a HPV High Risk (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66 and 68) panel result when the Pap test diagnosis is Atypical Squamous Cells (ASC) or Low Grade Squamous Intraepithelial Lesion (LSIL).
- 4 HPV DNA Primary Screen Reflex to Pap:
Providers will receive HPV 16, 18 and Other High Risk (HR) HPV type (31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68) results. If the results are HPV 16/18 negative and Other HR HPV positive, a reflex cytology Pap test will be performed at an additional charge.

Billing Information:

We will submit a claim for hospital related charges to your insurance, if appropriate, and send you a bill for any amount not covered by your insurance. PLEASE NOTE: Some test procedures may be reviewed by a physician who is not employed by RRMC. In these instances, you may receive a separate bill from that physician for their interpretation time. If you have questions about your bill, call 802.747.1751 or toll free 866.460.8277.

Assignment of Benefits, Release of Information, and Consent for Treatment:

I authorize RRMC to disclose my protected health information connected to this RRMC visit and treatment to my insurance company.

I am aware that RRMC privacy practices are further described in the RRMC Notice of Privacy Practices.

Signature of Patient _____ Date/Time _____

Witness _____ Date/Time _____