Laboratory Services
A Department of Rutland Regional Medical Center
160 Allen Street, Rutland, VT 05701 | www.RRMC.org | 802.747.1771

WOMEN'S HEALTH TEST REQUISITION
SPRINGFIELD CLIENTS

PATIENT NAME (LAST)	☐ Female ☐ Male
(FIRST) (INIT.)	DOB
PRINT PROVIDER NAME (LAST, FIRST)	
PROVIDER SIGNATURE DATE/TIME	

HPV Testing Options

Choose the HPV High Risk (HR) DNA testing based on the Pap Test Diagnosis:(See Back for Order Conditions)

☐ Co-testing[1] ☐ Co-Testing Reflex to Genotype[2]

☐ If ASC /LSIL Pap Diagnosis[3] ☐ No HPV Testing Requested

☐ **HPV DNA Primary Screen w/ Reflex to PAP test[4]**

TESTING PRIORITY	☐ Routine	☐ **STAT**

REQUIRED CLINICAL INFORMATION FOR PAP TEST AND HPV PRIMARY SCREEN ONLY

Specimen Date/Time: _____ LMP: _____

SAMPLE: ☐ THIN PREP ☐ CONVENTIONAL SMEAR (# OF SLIDES ___)

SOURCE: ☐ VAGINAL ☐ CERVICAL ☐ ENDOCERVICAL

BIRTH CONTROL PILLS: ☐ YES ☐ NO IUD: ☐ YES ☐ NO

PREGNANT: ☐ YES ☐ NO POSTPARDUM: ☐ YES ☐ NO

HORMONE THERAPY: ☐ YES ☐ NO CHEMO/RADIATION: ☐ YES ☐ NO

PREVIOUS PAP IN LAST 7 YEARS? ☐ YES ☐ NO ☐ DATE ___/___

PREVIOUS ABNORMAL PAP or ABNORMAL SURGICAL HISTORY IN LAST 3 YEARS? ☐ YES ☐ NO

IF YES TO ABOVE, PLEASE PROVIDE PREVIOUS ABNORMAL DATE AND DIAGNOSIS:

OTHER CLINICAL HISTORY/COMMENTS:

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.

☐ Routine Screening Pap Test	☐ High Risk Screening Pap Test	☐ Diagnostic Pap Test
☐ Routine Cervical Pap and Lab Report	☐ Routine Cervical Pap and Other history presenting hazard to health	☐ Previous Abnormal Pap test
	☐ High risk sexual behavior	☐ Post-Menopausal Bleeding
	☐ Asymptomatic HIV infection status	☐ Positive Cervical High Risk HPV DNA Test
		☐ Dysplasia of Cervix
		☐ ASCUS (Pap test of cervix with atypical squamous cells)
		☐ Unsatisfactory Cervical Cytology Test
☐ Other_____	Other_____	☐ Other_____

Molecular Testing Options

☐ **GTY Probe (Vaginal Pathogens: Gardnerella, Trichomonas, Candida)**	☐ 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

* 1 4 0 5 *

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

Requisition QC Check
Phlebotomist_____
Processor_____

See Reverse for Assignment of Benefits and Billing Information

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 _____