GYN-NY

PROPATH
A Sonic Healthcare Anatomic Pathology Practice

1355 RIVER BEND DRIVE
DALLAS, TX 75247
P 214.638.2000
P 800.258.1253
F 214.237.1731
www.ProPath.com

1 Patient Information

REQUIRED

Name: (Last) (First) (MI)
Address: Apt. number:
City: State: Zip code:
Phone: (Area code first) Birth date: Sex:
Social security number: Patient ID number:

2 Billing Information

REQUIRED

1) Submit copy of Patient's ID and insurance cards (front and back).
2) Medicare patients MUST complete ABN form (see reverse).

Bill to:
☐ Account ☐ Medicaid ☐ Insurance
☐ Patient (self-pay) ☐ Medicare

Relationship to insured:
☐ Self ☐ Dependent
☐ Spouse

Insurance company name: Employer name:
Name of insured: Policy / member ID #: Group #:
Mail claim to:
Address:
City: State: Zip code:

3 Provider Information

REQUIRED

Check appropriate box above to indicate ordering provider.
Referring provider: NPI#:

Send duplicate report to:
Name:
Address:
City/State/Zip:

PHYSICIAN ACKNOWLEDGEMENT (Required)

Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient.
Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached.

Physician's Signature: ______________________ **Date Ordered:** ______________

4 Diagnosis Codes

REQUIRED

Diagnosis code(s): Required for each test ordered.

1) ____________ 2) ____________ 3) ____________

5 Date

REQUIRED

Collection date and time:
M: ________ D: ________ Y: ________ Time: ____________

6 Clinical history

REQUIRED

☐ Routine exam
☐ High-risk exam
☐ Pregnant ____________ wks
☐ Postpartum ____________ wks
☐ Postmenopausal
☐ LMP (date): ____________

☐ Previous Pap
Date: ____________
☐ Result: ____________
☐ Previous biopsy / excision
Date: ____________
Result: ____________

☐ HPV positive
☐ Hysterectomy (total)
☐ Hysterectomy (partial)

☐ Radiation
☐ Chemotherapy
☐ Abnormal bleeding

☐ IUD
☐ OCP/Hormone Rx
☐ History of malignancy (specify below)

Colposcopic findings / impress / other information:
____
____
____

7 GYN cytology / HPV testing

Source: REQUIRED
☐ Cervix
☐ Endocervix
☐ Vagina
☐ Other (specify): ____________

☐ Standing order for Pap / molecular testing
☐ Age-based cervical cancer screening*A
☐ Age-based cervical cancer abd STI screening*B

*Includes Pap plus (based on patient age):
(A) HPV and HPV genotyping
(B) HPV, HPV genotyping, *C. trachomatis*, and *N. gonorrhoeae*.
See test menu for details.
(Selecting a test from menu at right will override any existing order)

Customized testing
☐ Pap only
☐ High-risk HPV only
  ☐ Reflex HPV genotyping*
☐ Pap with high-risk HPV (regardless of cytology result)
  ☐ Reflex HPV genotyping *

Pap with reflex high-risk HPV
☐ If ASC-US
☐ If ASC-US or LSIL
☐ Add reflex HPV genotyping*

*On the APTIMA HPV® platform, genotyping includes identification of types 16 and 18/45.

8 Molecular testing

Panel testing (ProPathSwab or ThinPrep vial):

☐ **Vaginitis**
- Candida
- Gardnerella
- Trichomonas

☐ **Leukorrhea**
- Candida
- Gardnerella
- Trichomonas
- Chlamydia
- Gonorrhea

☐ **STI Screening**
(for high-risk patients)
- Chlamydia
- Gonorrhea
- Trichomonas

☐ **Infertility**
- Chlamydia
- Gonorrhea
- Trichomonas
- Gardnerella

☐ **Reflex Candid speciation if Candida positive**

Individual testing (ProPathSwab or ThinPrep vial unless indicated):
☐ *Candida* species
  ☐ Reflex Candida speciation
☐ *Chlamydia trachomatis*
☐ *Gardnerella vaginalis*
☐ Group B *Streptococcus*
(BactiSwab required)
  ☐ Penicillin- allergic
  (reflex sensitivity testing if GBS positive)

☐ HSV 1 / 2 by PCR
☐ 24325 - *Mycoplasma genitalium* *
☐ *Neisseria gonorrhoeae*
☐ *Trichomonas vaginalis*

*ProPath swab or Aptima urine

Aptima Urine Specimen Transport Kit ☐ CT/NG ☐ TV ☐ M.gen.

9 Tissue pathology

Source:

A) ____________
____
B) ____________
____
C) ____________
____
D) ____________
____

10 Non-gynecologic cytology

Urine cytology:
☐ Voided
☐ Catheterized
☐ Bladder washing
  ☐ with FISH testing
  ☐ with reflex FISH testing if cytology atypical

Other cytology:
☐ Anal cytology
☐ Nipple discharge
  ☐ Left ☐ Right
☐ Fine needle aspiration
Source: ____________
☐ Other (specify): ____________
____

V67, 03/23

Please include the diagnosis code(s) at the highest level of specificity as documented in the patient medical record for this requisition date of service.

v.081722

The ABN is located on the back of the first copy of this requisition.

Please complete the appropriate information and ask the patient to sign the back of the first copy.

We appreciate your help.