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WOMEN'S HEALTH					
		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			
			Physician's and attached. Physician's Date Signature: Ordered: Ordered:		
BY		Z	Date collected:	REQUIRED	
REFERRED BY		ECIM	M: D: Y: Source:	Time: PM STAT	
REFE			Additional Testing from Pap and ProPath	Swab™	
			BV Expanded Panel PPS Only Chlamydia trachomatis and Neisseria gond	prrhoea Pap, PPS, UST	
			Genital mycoplasma panel PPS Infertility panel Pap, PPS		
	Send duplicate report to: (Last) (First)	Ā	STI screening panel (For high-risk patients) Pap, Leukorrhea panel Pap, PPS	, PPS, UST n reflex Candida speciation if Candida positive [†]	
соруто		Ш	See reverse for p	panel components	
ខ	Address: City: State: Zip: Fax:	MOL	Individual Testing:	Aptima Mycoplasma genitalium PPS, UST	
	Patient name: (Last) (First) (MI) REQUIRED		□ with refex Candida speciation [†] □ Gardneralla vaginalis (for BV) Pap, PPS	☐ Mycoplasma hominis PPS ☐ Syphilis (Treponema pallidum) PPS	
NO	Address: Apt. number:		 Herpes simplex virus 1 & 2 Pap, PPS Mycoplasma genitalium PPS 	☐ Trichomonas vaginalis Pap, PPS, UST ☐ Ureaplasma species PPS	
PATIENT INFORMATION		-	General Health:		
INFO	City: State: Zip:		□ Anti-nuclear antibodies (ANA) with reflex to antibody cascade [†] sst	Hemoglobin and hematocrit LAV Hepatic function panel SST	
LIENT	Phone: (Area code first) Birth date: Sex:		□ Basic metabolic panel <i>sst</i> □ C-reactive protein (CRP) <i>sst</i> □ CA125 <i>sst</i>	 ☐ Iron with TIBC ss7 ☐ Lactate dehydrogenase (LDH) ss7 ☐ Lipid panel ss7 	
PAI	Social security number: Patient ID number:	AL	CA15-3 SST	Protein, 24-hour urine <i>stc</i> (tv:) Prothrombin time with INR (PT/INR) <i>LBL</i>	
		I	Complete blood count (CBC) w/ differential LAV	 Activated partial thromboplastin time (APTT) LBL Rhematoid factor sst 	
	Bill To: Relationship to insured: REQUIRED Account Medicaid Insurance Self Dependent		Comprehensive metabolic panel <i>sst</i> Electrolyte panel <i>sst</i> (500)	□ Uric acid <i>ss</i> τ □ Urine drug screen <i>s</i> τ <i>c</i>	
	Patient (self-pay)		Erythrocyte sedimentation rate (ESR) LAV Ferritin SST Glucose GRY	 ☐ Urinalysis with reflex to microspopic and culture [†] <i>s</i>TC + <i>UCL</i> ☐ Vitamin B12 and folate <i>ss</i>T 	
NO	Insurance company name: Employer name:		Hemoglobin A1c LAV	Vitamin D, 25-hydroxy SST panel components	
BILLING INFORMATION	Name of insured: Policy / member ID: Group #		Hormones:	PTH (parathyroid hormone, intact) SST	
INFO	Mail claim to:		Anti-mullerian hormone (AMH) sst Cortisol AM sst	□ T3, free ssT □ T3, total ssT	
LING			Cortisol PM sst DHEA-S sst	\Box T4, free <i>ss</i> τ \Box T4 (thyroxine), total <i>ss</i> τ	
BIL	Address:		Estradiol (E2) <i>sst</i> FSH (follicle stimulating hormone) <i>sst</i>	Testosterone, total <i>SST</i> Testosterone, free and total w/SHBG <i>SST</i>	
	City: State: Zip:		 ☐ Human corionic gonadotropin (beta hCG) ssT ☐ LH (luteinizing hormone) ssT 	 Thyroid panel with TSH ssT TPO Ab (thyroid peroxidase antibody)ssT TOU (thyroid perioxidase antibody) ssT 	
	Attach copy of insurance card (front and back). Medicare patients MUST sign ABN form (see reverse)		Progesterone <i>sst</i> Prolactin <i>sst</i>	TSH (thyroid stimulating hormone) SST TSH w/ reflex to T4, free SST	
0	Diagnosis Code(s): REQUIRED			panel components	
ICD-10	1 2 3 4 Required for each test ordered.		 Hepatitis panel, acute <i>SST</i> Hepatitis Bs antigen w/ reflex to 	□ RPR w/reflex to titer and confirmation (Trep. Ab) ssτ	
	Clinical History:		confirmation ssT	\Box Rubella IgG <i>sst</i> \Box Syphilis Ab (Trep. Ab) w/reflex to RPR and	
ЛRY	□Routine exam □High-risk exam □Pregnantwks □Postpartumwks	CLINICAL	□ HIV antigen and antibody w/ reflex to confirmation [†] ssT	titer† <i>ssT</i> Toxoplasma Ab IgG <i>ssT</i>	
HISTO	Postmenopausal LMP (date): Previous Pap Date: Result:		□ HSV 1 and 2 type specific IgG ssT □ HSV 1/2 IgM ssT	Varcella-zoster IgG SST Zika IgM SST (frozen serum)	
CLINICAL HISTORY	Previous BX / excision Date: Result:			☐ Zika virus by NAA sst + Ust panel components	
CLIN	Impression / other information:	_	Microbiology: Anaerobic culture Genital culture BAC Source:		
-	Source:	Z	Respiratory culture BAC Source: Stool culture STC or STL Source:	Wound culture (aerobic)	
	Cervix / Endocervix Vagina Other:	Ŭ	Throat culture BAC Source:	Other (include Source):	
	Standing Order & Age-based Testing:		Pregnancy and Prenatal:	Carrier Screening: Cystic Fibrosis (CF)* LAV Spinal Muscular Atrophy (SMA)* LAV	
/HPV	(Selecting a test from the customized testing menu will override any existing standing order.) Age-based cervical cancer screening*		Antibody screen with reflex ID and Titer [†]	Spirial Museular Allophy (SIMA) LAV Fragile X* LAV *Informed Consent & Insurance Preauthorization Required	
GYN CYTOLOGY / HPV	Age-based cervical cancer and STI screening* Cervical caner screening — Pap and Age-based HPV plus CT/NG*		 Fetal fibronectin (fFN) Gestational diabetes GTT screen (1 hr, 50 g) 	AFP & Quad Screen History Please indicate test below, then complete	
SYTOI	Cervical cancer screening — Pap and Age-based HPV plus CT / NG / TV*	_	GRY	clinical history (REQUIRED)	
GΥΝ	Customized Testing: Pap only Pap with reflex high-risk HPV High-risk HPV only I if ASC-US	CLINICAI	□ Gestational diabetes GTT diagnostics (3 hr, 100 g) <i>GRY</i> □ Obstetric panel w / HIV <i>SST</i> (1) + <i>PNK</i> (1) +	Quad Screen <i>ss</i> T Clinical History:	
	High risk mer voluty with reflex HPC genotyping [†] Pap with high-risk HPV (regardless of cytology result) add reflex HPV genotyping [†]	ដ	$\Box Obsteinc panet w / Hiv SST (1) + PNK (1) + LAV (1) \Box TORCH IgG SST$	EGA as Listed in Sono: Date of Sono:	
	with reflex HPV genotyping [†] Genotyping performed on the APTIMA [®] HPV platform; genotyping includes identification of types 16 and 18/45		Group B Streptococcus BAC	LMP:	
	Source:		Fetal Gender Determination:	Weight: Insulin:	
ш			ProXY Gender Reveal LAV Gest. Age:	# Fetus: Race: panel components	
TISSUE	A: C:	õ	Urine Cytology:	Other Cytology:	
	B: D:		Urine Cytology		
		GYN	☐ if atypical or suspicious ☐ if atypical, suspicious, or malignant	☐ Fine needle aspiration	
		NON	Urine cytology and urinary FISH Source: Voided Catheterized Bladder		
		Ot	ther:		
		BAC	C BactiSwab [™] - Amies transport medium w/ or w/o charcoal P	PS ProPathSwab ^w — Aptima Swab (Unisex Swab, Multitest Swab) NK Pink vacutainer — Potassium EDTA (K2 or K3 EDTA) ED Red vacutainer — No gel (no anticoagulant)	
		FFN	V Fetal Fibronectin Swab Gray vacutainer — Potassium oxalate and sodium flouride S Lavender vacutainer — Potassium EDTA (K22 or K3 EDTA) S	TC Sterile cup TL Sterile cup or Cary-Blair medium vials ST Bed/Gray clot activator + gel separator	
		LBL	L Light blue vacutainer — Sodium citrate U	ICL Urine culture tube w/ boric acid preservative IST Aptima® Urine Specimen Transport Tube	

* See reverse for age-based protocol (HPV/STI Testing).
 + Reflex tests will be performed at an additional charge. Visit www.propath.com for more information.
 + Informed consent required.

All panel components can be ordered separately. See reverse or visit www.propath.com.

Internal Use Only Draw: DPHLEB CRFPHLB REV 11/22