



Valley Regional Hospital

243 Elm Street . Claremont, NH 03743-2099
603 543-5641 or 603 543-5619

Cytology #:	_____
Date Rec'd:	_____
MR#:	_____
Billing #:	_____

CYTOLOGY

SS # _____ SEX _____ DOB _____ MAIDEN NAME _____

NAME, LAST _____ FIRST _____ MI _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE: _____ RESPONSIBLE PARTY (IF CHILD) _____ CHART # _____

INSURANCE _____ POLICY _____ GROUP _____

INSURANCE _____ POLICY _____ GROUP _____

PHYSICIAN _____ COPIES TO _____

COLLECTION DATE _____

A Diagnosis MUST be included <i>Check one box.</i>		GYNECOLOGIC INFORMATION		
SCREENING PAP TEST		SOURCE: <input type="checkbox"/> CERVICAL-ENDOCERVICAL-VAGINAL <input type="checkbox"/> VAGINAL		
Screening, no symptoms V 72.6 V 76.2		CHECK ONLY THE BOXES THAT APPLY		
High Risk due to personal Hx. V 72.6 V 15.89		LMP ____ / ____ / ____	<input type="checkbox"/> IUD <input type="checkbox"/> PMB <input type="checkbox"/> HYSTERECTOMY <input type="checkbox"/> TOTAL <input type="checkbox"/> PARTIAL <input type="checkbox"/> MENOPAUSE	ABNORMAL GYN HISTORY (< 5 Years)
DIAGNOSTIC PAP				<input type="checkbox"/> COLPOSCOPY <input type="checkbox"/> PREVIOUS ABNORMAL PAP DATE: _____ <input type="checkbox"/> BIOPSY DATE: _____ <input type="checkbox"/> OTHER
Diagnosis:		<input type="checkbox"/> HRT/HORMONAL CONTRACEPTIVE		
Diagnosis Code:		<input type="checkbox"/> PREGNANT		
		<input type="checkbox"/> POST PARTUM		
CLINICAL HISTORY:		HPV TESTING (Liquid Based Only)		
		<input type="checkbox"/> HPV (High Risk) Regardless of PAP Test Results <input type="checkbox"/> HPV (High Risk) ONLY (No PAP Test)		
NON GYN SPECIMEN SITE Left _____ Right _____		NOTE: HPV Testing WILL be performed on ALL "ASCUS" PAPS unless specified <input type="checkbox"/> NO HPV TESTING		
<input type="checkbox"/> Brushing (Site) _____ <input type="checkbox"/> Ovarian Cyst Fluid <input type="checkbox"/> Washing (Site) _____ <input type="checkbox"/> Pelvic Fluid <input type="checkbox"/> CSF <input type="checkbox"/> Peritoneal Fluid <input type="checkbox"/> FNA (Site) _____ <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Other _____ <input type="checkbox"/> Sputum <input type="checkbox"/> Urine - Specify (Voided - Catheter)		FOR LAB USE ONLY		
LAB USE ONLY		Gross Description	Processing	
		Volume _____	# Smears/Cytospins _____	
		Fixed Yes _____ No _____	Cell Block _____	
		CRR _____	Tech Assist _____	
		Consistency _____	Prep Tech _____	
		Bloody Yes _____ No _____		
		Color _____		
		Clotted Yes _____ No _____		
		Other: _____		
Form # 7020.110 Revised 2/2007				