



Hagerstown  
Medical Laboratory

Date: September 23, 2010  
To: Clients of Hagerstown Medical Laboratory, Inc.  
From: John G. Newby, M.D., Director of Laboratories  
Subject: Revised Gynecologic Cytology (PAP) Requisition

In order to better serve our clients, Hagerstown Medical Laboratory (HML) has recently revised its Gynecologic Cytology (PAP) Requisition as follows:

1. An additional Diagnosis is now listed-

**ROUTINE ICD-9 V73.81**   
(routine screening for high risk Human papillomavirus (HPV) for women aged 30 and over)

2. HML reflexes HPV testing from THIN PREP's only on ASCUS (Atypical Squamous Cells of Undetermined Significance). Therefore, **THIN PREP WITH TRIAGE REFLEX (ASCUS only, High Risk HPV only)** has been edited to more clearly reflect the American College of Obstetricians and Gynecologist (ACOG) guidelines which HML follows, and now reads as:

**THIN PREP WITH HIGH RISK HPV TRIAGE REFLEX (ASCUS only)**

*Please note that Pathologists' findings of AGUS (Atypical Glandular cells of Undetermined significance) and/or ASC-H (Atypical Cells of Undetermined significance; can not rule out High Grade Squamous Intraepithelial Lesion) alone will NOT reflex HPV testing. Ordering providers do have the option to "Add-on" HPV testing up to 1 month after a normal report is signed out and up to 3 months after an abnormal report is signed out by submitting a completed Physician Authorization Form (attached).*

3. Under the Clinical History Questionnaire section, when checking "Yes" to the Hysterectomy Query, the ordering provider should now also check the appropriate new box denoting whether it was a "Total" or "Supracervical" Hysterectomy-

Hysterectomy.....Yes  No   
If yes, Total  or Supracervical

A copy of HML's new Gynecologic Cytology (PAP) Requisition is attached and supplies of this new form are now available. Questions about these changes should be directed to HML Client Support Services at 301-665-4900 or 1-800-428-2105.



**HAGERSTOWN MEDICAL LABORATORY**  
Suite 230, 11110 Medical Campus Road, Hagerstown, MD 21742

**GYNECOLOGIC CYTOLOGY**

|                     |
|---------------------|
| Case # _____        |
| <b>LAB USE ONLY</b> |

|  |  |  |   |                   |  |                              |   |  |     |  |  |
|--|--|--|---|-------------------|--|------------------------------|---|--|-----|--|--|
| PATIENT NAME last first m.i.   |  |  | BIRTHDATE<br>MO. DAY YEAR   |                   |  | REQUEST DATE<br>MO. DAY YEAR |   |  |     |  |  |
| MAIDEN NAME OR PREVIOUS LAST NAME  |  |  |   | SOCIAL SECURITY # |  |                              | <input type="checkbox"/> Male <input type="checkbox"/> Female |  |     |  |  |
| STREET ADDRESS   |  |  | CITY  |                   |  | STATE                        |   |  | ZIP |  |  |
| TELEPHONE NO.<br>( )   |  |  | MARITAL STATUS<br><input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED |                   |  |                              |   |  |     |  |  |
| BILL TO<br><input type="checkbox"/> CLIENT <input type="checkbox"/> PATIENT <input type="checkbox"/> INSURANCE |  |  | NURSE COMPLETING FORM   |                   |  |                              | REQUESTING PHYSICIAN  |  |     |  |  |

|   |                              |  |                                |  |                         |                     |
|---|------------------------------|--|--------------------------------|--|-------------------------|---------------------|
| <b>Primary Insurance</b>                              | Name of Insurance Company    |  | Name of Insurance Policyholder |  | Relationship to Patient |                     |
|   | Insurance No. - Policy/Group |  | Address of Policyholder        |  |                         | Social Security No. |
| <b>Secondary Insurance</b>                            | Name of Insurance Company    |  | Name of Insurance Policyholder |  | Relationship to Patient |                     |
|   | Insurance No. - Policy/Group |  | Address of Policyholder        |  |                         | Social Security No. |
| SIGNED (PATIENT, OR PARENT IF MINOR) _____ (required) |                              |  |                                |  |                         |                     |

**DIAGNOSIS (REQUIRED FOR PROCESSING)**

ROUTINE ICD-9 V76.2   
(absence of signs or symptoms of disease)

HIGH RISK ICD-9 V15.89   
(includes: early onset of sexual activity (under age 16); multiple sex partners (five or more in a lifetime); history of sexually transmitted disease; fewer than three negative or any Paps within the previous seven years; having a mother who took DES during pregnancy)

ROUTINE ICD-9 V73.81   
(routine screening for high risk Human papillomavirus (HPV) for women aged 30 and over)

ADDITIONAL DIAGNOSIS: \_\_\_\_\_

**FOR MEDICARE PATIENTS A SIGNED ABN MUST BE SUBMITTED**

|  |  |
|--|--|
| <input type="checkbox"/> PAP SMEAR   | <input type="checkbox"/> CERVICAL-<br>ENDOCERVICAL<br><input type="checkbox"/> VAGINAL |
| <input type="checkbox"/> THIN PREP   |  |
| <input type="checkbox"/> THIN PREP + HPV   |  |
| <input type="checkbox"/> THIN PREP WITH HIGH RISK HPV TRIAGE REFLEX (ASCUS only) |  |

|   |  |
|---|--|
| Last menstrual period _____ / _____ / _____   | Post Menopausal..... Yes <input type="checkbox"/> No <input type="checkbox"/>    |
| Pregnant..... Yes <input type="checkbox"/> No <input type="checkbox"/>                          | If yes, number of years _____  |
| Post Partum..... Yes <input type="checkbox"/> No <input type="checkbox"/>                       | Hysterectomy..... Yes <input type="checkbox"/> No <input type="checkbox"/>       |
| Previous abnormal smear or biopsy..... Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes, Total <input type="checkbox"/> or Supracervical <input type="checkbox"/> |
| Laser TX..... Yes <input type="checkbox"/> No <input type="checkbox"/>                          | Radiation TX _____ Yes <input type="checkbox"/> No <input type="checkbox"/>      |
| Contraceptive ..... Yes <input type="checkbox"/> No <input type="checkbox"/>                    | Hormone TX ..... Yes <input type="checkbox"/> No <input type="checkbox"/>        |
|   | Physician Chart # _____  |

**MISC. SPECIMEN** \_\_\_\_\_

Clinical History/Diagnosis \_\_\_\_\_

## Department of Cytology



### Physician Authorization Form

|               |      |
|---------------|------|
| Patient Name: | DOB: |
| Diagnosis:    | Sex: |
| Physician:    | ID#: |

Our office sent a specimen on \_\_\_\_\_ for cytologic examination that had a finding of ASCUS or above.

In order to provide an accurate diagnosis and allow the physician to determine the appropriate course of treatment, I am requesting the addition of the following test(s).

HPV (High-Risk Only)

\_\_\_\_\_

Please sign and date below to indicate your authorization for above testing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Any Questions call 301-665-4921 or 4923**

**Please Fax this form back to Cytology at 301-665-4949**