

160 Allen Street, Rutland, VT 05701 | www.RRMC.org | 802.747.1771

PATIENT NAME (LAST)		<input type="checkbox"/> Female	Required Clinical Information for PAP TEST and HPV PRIMARY SCREEN Only	
(FIRST) (INIT.)		<input type="checkbox"/> Male	Specimen Date/Time: _____ LMP: ____/____/____	
DOB		Source <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical/Endocervical		
PRINT PROVIDER NAME (LAST, FIRST)		Contraceptives <input type="checkbox"/> Intrauterine Device (IUD) <input type="checkbox"/> Depo-Provera <input type="checkbox"/> Oral/Hormone Therapy		
PROVIDER SIGNATURE		Is Patient? <input type="checkbox"/> Pregnant <input type="checkbox"/> Post-Partum <input type="checkbox"/> Post-Menopausal		
DATE/TIME		<input type="checkbox"/> Post-Hysterectomy <input type="checkbox"/> Post Chemo/Radiation Therapy		
HPV Testing Options (See Back for Order Conditions)		HPV Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Choose the HPV High Risk (HR) DNA testing based on the Pap Test Diagnosis:		If not at RRMC, Previous Pap within 7 yrs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Date ____/____/____		
<input type="checkbox"/> Co-Testing with Genotype ¹ <input type="checkbox"/> If ASC /LSIL Pap Diagnosis ²		If not at RRMC, Previous Abnormal within 3 yrs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> No HPV Testing Requested		If yes to above, please provide previous abnormal date and diagnosis:		
TESTING PRIORITY <input type="checkbox"/> Routine <input type="checkbox"/> STAT		Other clinical history/comments:		

Providers are Required to Complete the Following Sections

Select Pap Test Type. Providers must determine if the Pap Test is submitted as a **SCREENING** or **DIAGNOSTIC** Laboratory test.

ThinPrep Screen ThinPrep Diagnostic Conventional Screen Conventional Diagnostic

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 Cervical Pap and Lab Report Unsatisfactory Cervical Cytology Test Previous Abnormal Pap test

Post-Menopausal Bleeding Positive Cervical High-Risk HPV DNA Test Dysplasia of Cervix Other: _____

Molecular Testing Options

<input type="checkbox"/> HPV DNA Primary Screen w/ Reflex to PAP test ³ (Complete Clinical Information above)	Diagnosis (Signs and Symptoms):
<input type="checkbox"/> Chlamydia DNA PCR <input type="checkbox"/> Urine <input type="checkbox"/> Swab <input type="checkbox"/> ThinPrep	
<input type="checkbox"/> Gonococcus DNA PCR <input type="checkbox"/> Urine <input type="checkbox"/> Swab <input type="checkbox"/> ThinPrep	
<input type="checkbox"/> GTY Probe (Vaginal Pathogens: Gardnerella, Trichomonas, Candida)	

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

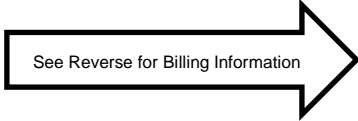
Assignment of Benefits, Release of Information, and Consent for Treatment

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 _____



FOR RRMC USE ONLY

Lab Specimen No. _____

Date Received: _____

Requisition QC Check

Phlebotomist _____

Processor _____

PATIENT LABEL



* 1 4 0 5 *

HPV Testing Options and Reflex Orders: Additional Testing will be performed if certain criteria are met.

1 HPV HR DNA Co-Testing With Genotype

Providers will receive a genotyping result for HPV 16, HPV 18 and Other High Risk HPV types (31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68).

2 HPV HR DNA if ASC / LSIL PAP DIAGNOSIS

Providers will receive a genotyping result for HPV 16, HPV 18 and Other High Risk HPV types (31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68) when the Pap test diagnosis is Atypical Squamous Cells (ASC) or Low Grade Squamous Intraepithelial Lesion (LSIL).

3 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.