Laboratory Services
A Department of Rutland Regional Medical Center

WOMEN'S HEALTH TEST REQUISITION

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

PATIENT NAME (LAST)	☐ Female ☐ Male
(FIRST) (INIT.)	DOB
PRINT PROVIDER NAME (LAST, FIRST)	
PROVIDER SIGNATURE	DATE/TIME

HPV Testing Options (See Back for Order Conditions)

Choose the HPV High Risk (HR) DNA testing based on the Pap Test Diagnosis:

☐ Co-Testing with Genotype[1] ☐ If ASC /LSIL Pap Diagnosis[2]

☐ No HPV Testing Requested

TESTING PRIORITY ☐ Routine ☐ **STAT**

Required Clinical Information for PAP TEST and HPV PRIMARY SCREEN Only

Specimen Date/Time: _____ LMP: ____/____/____

Source ☐ Vaginal ☐ Cervical/Endocervical

Contraceptives ☐ Intrauterine Device (IUD) ☐ Depo-Provera ☐ Oral/Hormone Therapy

Is Patient? ☐ Pregnant ☐ Post-Partum ☐ Post-Menopausal ☐ Post-Hysterectomy ☐ Post Chemo/Radiation Therapy

HPV Vaccine? ☐ Yes ☐ No

If not at RRMC, Previous Pap within 7 yrs? ☐ Yes ☐ No ☐ Date ____/____/____

If not at RRMC, Previous Abnormal within 3 yrs? ☐ Yes ☐ No

If yes to above, please provide previous abnormal date and diagnosis:

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

☐ **HPV DNA Primary Screen w/ Reflex to PAP test[3]** (Complete Clinical Information above)				**Diagnosis (Signs and Symptoms):**
☐ **Chlamydia DNA PCR**	☐ Urine	☐ Swab	☐ ThinPrep	
☐ **Gonococcus DNA PCR**	☐ Urine	☐ Swab	☐ ThinPrep	
☐ **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 _____

See Reverse for Billing Information

FOR RRMC USE ONLY
Lab Specimen No.
Date Received:

Requisition QC Check
Phlebotomist_____
Processor_____

PATIENT LABEL

White ➔ Lab
Yellow ➔ Provider/Clinic

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.