Scott & White

SWRL PAP Requisition

TEMPLE, TEXAS 76508
PH: 254-724-5221 FAX: 254-724-5466

Patient Name: _____

Patient ID: _____

Date of Birth: _____

Date of Service: _____

Ordering Physician: _____

ICD-9 Diagnosis Code: _____

Source (Required)

- ☐ Cervical/Endocervical
- ☐ Vaginal
- ☐ Endocervical Only
- ☐ Other: _____

PAP Category: (Required)

- ☐ Diagnostic PAP Test
- ☐ Non-Medicare Routine Screening PAP
- ☐ Medicare Low-Risk Screening PAP >/=2 yrs
- ☐ Medicare High-Risk Screening PAP

Collection: (Required)

- ☐ Liquid Based PAP Test Only, **No Reflex Testing**
- ☐ Liquid Based PAP Test, if **ASCUS, perform Reflex HPV Assay**
- ☐ Liquid Based PAP Test, **if ASCUS or negative, perform Reflex HPV Assay**
- ☐ Liquid Based **PAP Test and Perform HPV Assay**
- ☐ Conventional PAP Test

PAP History: (Required)

Prior PAP date: _____/_____/_____

- ☐ None Available
- ☐ Prior PAP Results:
  - ☐ Negative
  - ☐ ASCUS
  - ☐ LSIL
  - ☐ HSIL
  - ☐ Squamous Cell Carcinoma
  - ☐ Endocervical Adenocarcinoma
  - ☐ Endocervical AIS
  - ☐ Other (note in Comments)

Number of Vials Submitted: (Required) _____

Menstrual History:

- ☐ Pregnant_____ weeks
- ☐ Postpartum _____ weeks
- ☐ Breastfeeding
- ☐ Postmenopausal _____ (Year)
- ☐ Contraception _____
  - ☐ IUD
  - ☐ Oral
  - ☐ Other _____
- ☐ Abnormal bleeding/Spotting
- ☐ Premenstrual

Last Menstrual Period: _____/_____/_____ (Required)

Clinical History: (Check all that apply)

- ☐ Hysterectomy - Total _____ (Year)
- ☐ Hysterectomy - Partial
- ☐ LEEP / Cone Biopsy
- ☐ Cryotherapy / Laser
- ☐ Colposcopy and biopsy
- ☐ Chemotherapy
- ☐ Radiation
- ☐ History of Malignancy
- ☐ No Clinically Significant History
- ☐ None Available

Clinical Impression/History (Required):

_____

_____

Comments:

_____

_____

2-2008