HAC Gynecological Cytology Form

ALLINA MEDICAL LABORATORIES
Allina Hospitals & Clinics

Name _____ DOB _____

SSN _____ Physician _____

Date of Collection _____ Diagnosis _____

Conventional Pap Smears (Order on Routine Tab)

☐ Conventional PAP (Quest)
Type: ____Routine/Screening ____Diagnostic
Source: ____Cervix ____Endocervix ____Vagina

Cytology Order (Check for ALL Thin Prep Orders, Order on Cytology Tab)

☒ **GYN Order Test (Always Order)**

Thin Prep Pap Smear ONLY (No Reflex HPV Tests)

☐ Thin Prep Pap Screen (Routine) V76.2
☐ Thin Prep Pap Screen (High Risk) V15.89
☐ Thin Prep Pap Diagnostic (Supply Dx)
☐ Thin (Hyst due to non-malig) V76.47, V45.77
☐ Thin (Hysterectomy due to malignancy) Supply Dx

Thin Prep Pap w/ Reflex HPV, Dx ASCUS (High/Intermediate risk types only)

☐ Reflex HPV Thin Prep Scrn (Routine) V76.2
☐ Reflex HPV Thin Prep Scrn (High Risk) V15.89
☐ Reflex HPV Thin Prep Diagnostic (Supply Dx)
☐ Reflex HPV Thin (Hyst - Non-malignant) V76.47, V45.77
☐ Reflex HPV Thin (Hyst due to malig) Supply Dx

HPV only, NO PAP Smear (High/Intermediate risk types only)

☐ Human Papillomavirus (Thin Preps Only) (Supply Dx)

Menstrual Status

***Last Menstrual Period (mmddyyyy)** _____ **(REQUIRED INFORMATION)**
☐ Abnormal Bleeding
☐ Hysterectomy
☐ Menopause
Pregnant (# weeks) _____
Postpartum (# weeks) _____
Hormone Usage (type) _____

Previous Cytology

***Previous Pap (date)** _____ **or**
☐ Negative
☐ Benign Cellular Changes **(BCC)**
(reactive, microorganisms, atrophy, postpartum)
☐ Atypical Squamous Cells **(ASCUS)**
☐ Atypical Glandular Cells **(AGCUS)**
☐ Unsatisfactory
☐ Other _____
☐ **NONE (REQUIRED INFORMATION)**
☐ Low grade squamous intraepithelial lesion **(LGSIL)**
Hpv/Mild dysplasia/CIN I
☐ High grade squamous intraepithelial lesion
(HGSIL) Severe dysplasia/CIN 2-3/CIS
☐ Carcinoma (squamous or adenocarcinoma)

Previous **Colposcopy/Bx** _____ **or** ☐ **NONE**
Results _____
***Colposcopy Today:** ☐ Yes ☐ No

Clinical Information

Appearance of Cervix _____
☐ Cervix Absent
Other Clinical Information _____

Previous Treatments

☐ None
☐ Cone Biopsy
☐ Cryo*
☐ LEEP*
☐ History of Malignancy*
☐ Chemotherapy*
☐ Radiation*
☐ DES Exposure*

Dates and Explanations of * Item(s) _____