MANCHESTER MEMORIAL HOSPITAL
71 Haynes Street, Manchester, CT 06040

ROCKVILLE GENERAL HOSPITAL
31 Union Street, Vernon, CT 06066

CYTOPATHOLOGY/DEPARTMENT OF PATHOLOGY

Dennis G. O'Neill, M.D. | Medical Director of Pathology and Laboratory Services

PATIENT DATA

PATIENT NAME *(Last)* *(First)* *(M.I.)*	SEX ☐ MALE ☐ FEMALE	ACCESSION NO.
STREET / TOWN/CITY / STATE / ZIP CODE		DATE RECEIVED
SOCIAL SECURITY NO. XXX-XX- / AGE / DATE OF BIRTH	PHONE *(HOME)* *(WORK)*	DATE OF COLLECTION

BILLING INFORMATION Please complete below *(a photocopy of the insurance card would be appreciated).*

PRIMARY INSURANCE: NAME/ADDRESS

I.D. #

GROUP #

POLICYHOLDER'S NAME/ADDRESS

RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

POLICYHOLDER'S EMPLOYER/ADDRESS

SECONDARY INSURANCE: NAME/ADDRESS

I.D. #

GROUP #

POLICYHOLDER'S NAME/ADDRESS

RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

MEDICAL RELEASE
I authorize the release of any medical information to process a claim and request payment of any medical insurance benefits to Eastern Connecticut Health Network, Inc. / Eastern Connecticut Pathology Consultants, P.C.

SIGNATURE DATE Authorization Expiration Date

MEDICARE PATIENTS - *WAIVER OF LIABILITY (IF APPLICABLE)*
I have been informed that Medicare will not cover yearly Pap testing in my case. I agree to be personally responsible for payment.

SIGNATURE DATE

TO BE COMPLETED BY PHYSICIAN OFFICE

M.D.OFFICE DATA

GYN CYTOLOGY

☐ LIQUID BASED PAP ☐ CONVENTIONAL PAP

SOURCE:
☐ CERVIX / ENDOCERVIX ☐ VAGINA

For Medicare patients, please check below:
☐ Increased risk for cervical cancer:
☐ YES ☐ NO
IF "NO", and this Pap smear is being performed more frequently than every 2 years, please review and check below:
☐ I have informed the patient that Medicare will not cover yearly Pap testing in her case and have obtained a "signed waiver of liability." (See above)

TESTS REQUESTED
- ☐ ROUTINE SCREENING
- ☐ REPEAT/DIAGNOSTIC
- ☐ HPV WITH 16/18 GENOTYPE FOR:
  - ☐ ANY DIAGNOSIS (Cotest)
  - ☐ ASCUS
  - ☐ NEGATIVE OR ASCUS
  - ☐ LSIL
  - ☐ HPV ONLY
- ☐ GC/CHLYMADIA

CLINICAL HISTORY
LMP (REQUIRED):
- ☐ INCREASED RISK FOR CERVICAL CANCER
- ☐ ABNORMAL BLEEDING
- ☐ PRENATAL
- ☐ POSTPARTUM
- ☐ POSTMENOPAUSAL
- ☐ HORMONE RX
- ☐ HYSTERECTOMY — ☐ COMPLETE/TOTAL / ☐ SUPRACERVICAL
- ☐ OTHER

NON-GYN CYTOLOGY

SITE:

CLINICAL HISTORY / ICD10:

PRACTITIONER/AHP SIGNATURE ____________ DATE ________ TIME ________

PRINT NAME/MNEMONIC ____________ COPY TO: ____________

FOR LAB USE ONLY

LAB DATA

GYN: SPECIMEN ADEQUACY
- ☐ EC COMPONENT
- ☐ SATISFACTORY
- ☐ LIMITED BY ________
- ☐ UNSATISFACTORY ________

GENERAL CATEGORY
- ☐ NILM
- ☐ OTHER
- ☐ ECA
- ☐ NOT GIVEN

SCREENED BY:

NON-GYN:
- ☐ NEGATIVE FOR MALIGNANCY
- ☐ INDETERMINATE FOR MALIGNANCY
- ☐ POSITIVE FOR MALIGNANCY
- ☐ NON-DIAGNOSTIC
- ☐ INSUFFICIENT FOR DIAGNOSIS

DATE: ____ / ____ / ____

SPECIMEN DESCRIPTION:

DESCRIPTIVE DIAGNOSIS / COMMENTS