# ROLLING OAKS
## Cytopathology Consultants, Inc.

CLIA ID: 10D2020904

# CYTOLOGY REQUISITION FORM

18200 SW 52nd CT
Southwest Ranches, FL 33331
Ph: (954)892-4605 • Fax: 1(888)473-3515

**Patient Information:** Name:________________________ **DOB** ____/____/____ **Sex:** ☐M ☐F

SSN: _____ - ____ - _______ Address: ________________________

City: ________________ State: _______ ZIP:____________ Phone: ________________

**Collection Date**: ________________ **Patient ID:**____________ **Submitting Physician:**________________

**BILL TO:** ☐Client ☐Insurance ☐Medicare ☐Medicaid

| INSURANCE CO. | SUBSCRIBER # | GROUP # | DOB | ICD 9 DIAGNOSIS CODE |
|---|---|---|---|---|
| | | | | |

**Specimen Source:** ☐Cervix ☐Vaginal ☐Endocervix **Type:** ☐Conventional ☐Liquid Based (Thin-prep) ☐HPV ☐Gonorrhea ☐Chlamydia

**Clinical History:**

Date of Last PAP: ___ / ___ / ___ LMP: ____ / ____ / ____ ☐Regular ☐ Irregular ☐Pregnant ☐Post-Partum ☐ Postmenopausal

Prior Abnormal: ________________ on _____ / _____ / ______ Prior Biopsy/Curettings on ______ / _______ / ______ Contraceptive: ☐Oral ☐IUD ☐Other

**Previous Cytology:** CIRCLE: NIL ASC LSIL HSIL CA GIVE DATE REPORTED IF DONE AT OUR LABORATORY ________________

**Present Complaint or Physical Findings:**

- ☐ ABNORMAL BLEEDING
- ☐ HYSTERECTOMY
- ☐ MENOPAUSAL SYNDROME
- ☐ DISCHARGE
- ☐ VAGINITIS
- ☐ ADDITIONAL HISTORY - Use Reverse Side

- ☐NORMAL
- ☐CERVICITIS
- ☐BLEEDS ON CONTACT
- ☐CLINICALLY SUSPICIOUS

AUTHORIZATION: I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to ROLLING OAKS CYTOPATHOLOGY CONSULTANTS, INC.

Signature of patient or responsible party Date



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R.O.C.C. www.RollingOaksCytology.com