

LTR12084



Blanchard Valley Hospital
1905 S. Main St., Findlay, Ohio 43840
Bluffton Hospital
139 Garraway St., Bluffton, Ohio 43817

**DEPARTMENT of CYTOLOGY
REQUEST FOR CYTOLOGY
EXAMINATION**

PURPOSE OF SMEAR:

TYPE OF SPECIMEN

Reg. Periodic Exam _____ Cervical Scrape _____
Follow-up Exam _____ Endocervical Brush _____
Vaginal Scrape _____

Birthdate: _____ Social Sec# _____
Home Phone: _____ Medicare # _____
Marital Status (M,D,S,W) _____ Medicaid # _____
New Address ___ Yes

To be filled in by Attending Physician

Physician(s) Name _____ Physician(s) Address _____

Menses - LMP
MO DAY YR
____/____/____

Circle All That Applies

Hormonal RX
Radiation RX
Specify Prev. malignancy

Patient Name: _____

PLEASE CIRCLE

Regular
Irregular
Abn. Bleeding
Post Menopausal
Now Pregnant
Post Partum

Hysterectomy:
Cryotherapy/laser Rx

Pt Address: _____

Collection Date _____

**PLEASE INCLUDE
INSURANCE INFORMATION**

_____ HPV Hybrid Capture Typing 04/02/07 dls

_____ HPV Hybrid Capture test, ONLY if pap diagnosis is ASCUS



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