

LABORATORY REQUISITION/PAP SMEAR, DATA RETRIEVAL

Lab Use Only

ACC.#: \_\_\_\_\_

REC'D DATE: \_\_\_\_\_

PLEASE PRINT FIRMLY AND CLEARLY USING BLACK OR BLUE INK ONLY

MEDICAID NUMBER: \_\_\_\_\_ PHOCIS ID: \_\_\_\_\_

PROGRAM INFORMATION:  FAMILY PLANNING  MATERNITY  TAKE CHARGE!  OTHER

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI \_\_\_\_\_

MEDICAID LAST: \_\_\_\_\_ MEDICAID FIRST: \_\_\_\_\_

MAIDEN/(prev.): \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

COLLECTION DATE: \_\_\_\_\_ COUNTY NAME: \_\_\_\_\_ CLINIC SITE #:

DONE BY NAME (PRINT): \_\_\_\_\_ TITLE \_\_\_\_\_

SPEC SITE: CIRCLE ONE Cervix (Pap.) Vaginal Cx. Biopsy ECC Breast Other: \_\_\_\_\_

LMP: \_\_\_\_\_ CURRENTLY PREG: (Circle One) Yes, V22.1 No, V25.09

G#: \_\_\_\_\_ P#: \_\_\_\_\_ B.C.: Pills, Depo, F/C, IUD, Oth, None HRT: Yes No HPV: Co-testing Reflex

PAP TESTING

DATE OF LAST PAP: \_\_\_\_\_ WHERE? OSDH PVT Unk

LAST PAP RESULTS: (Specify) \_\_\_\_\_

ABNORMAL PAP

DATE OF LAST ABN PAP: \_\_\_\_\_ RESULTS: ASCUS LSIL HSIL Cancer

PREV. TREATMENT(S): Cryo Laser Cone Bio. Rad/Chem LEEP/LLETZ Hyst. Unk

DATE: \_\_\_\_\_ WHERE? OSDH PVT Unk

OTHER MEDICAL PROBLEMS (that might affect results) \_\_\_\_\_

BREAST BIOPSY

CBE RESULTS: Nor Abn Unk MAMMOGRAM/ULTRASOUND RESULTS: Nor Abn (Specify)

COMMENTS:

Cytopathology Use Only

1200 N. Everett Drive, Oklahoma City, OK 73104 (405) 271-5507

CYTOTECH CODE COMMENTS

Diagnosis: \_\_\_\_\_

Cyto Tech Initials: \_\_\_\_\_ Date: \_\_\_\_\_

PATHOLOGIST CODE COMMENTS

Diagnosis: \_\_\_\_\_

Pathologist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Quality Control Done?  Yes Initials \_\_\_\_\_ Date: \_\_\_\_\_

Oklahoma State Department of Health Chronic Disease Services

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