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Park St. Glens Falls, NY 12801
Phone: 5
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www.glensfallshospital.org

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial): _____

Date of Birth: _____/ _____/ _____

PATHOLOGY *ALL fields under applicable category REQUIRED *

CYTOLOGY / SURGICAL

Surgical Biopsy? ☐ NO ☐ YES

Cytology non-gynecologic specimen? ☐ NO ☐ YES

Specimen source name : **(Please include side/lobe/upper/lower as applicable)**

_____

_____

Any ancillary tests that should be performed on this specimen :

_____

_____

Clinical history / reason for specimen procedure:

_____

_____

_____

_____

_____

Please indicate ALL Clinicians / Oncologists that should recieve a copy of the associated reports :

_____

_____

_____

_____

PAP SMEAR

Source? ☐ Endocervical ☐ Cervical ☐ Vaginal

Pregnant? ☐ NO ☐ YES

Postpartum? ☐ NO ☐ YES

Postmenopausal? ☐ NO ☐ YES

Hysterectomy? ☐ NO ☐ YES

Pap Smear Order:

☐ Pap *REFLEX* HPV **(will reflex to HPV only if diagnosis is ASCUS)**

☐ Pap w/ HPV

☐ Pap w/ HPV & CT/NG

☐ Pap w/ HPV & CT/NG & Trichomonas

Clinical Information:

LMP Date: _____ / _____ / _____

Relevant Patient History:

_____

_____

_____

_____

_____

Continued from front - OTHER TESTS/SPECIAL INSTRUCTIONS:

For tests not listed, please visit the test directory at www.labcorp.com/test-menu/search and indicate test code(s) from website in the box above.