VITRO MOLECULAR
LABORATORIES

8700 W Flagler Street
Miami, FL 33174
Ph: (305) 267-7979
Fx: (786) 513-0175

GYN REQUISITION FORM

EIN: 20-4506043 | **CLIA:** 10D1055514

Patient Information

Last	First	MI

DOB	Last 4 of SSN	☐ F ☐ M

Address

City	State	ZIP	Phone

Insurance Information

☐ Bill to Insurance: Copy ID Cards Front & Back ☐ Bill Physican

Name of Carrier	Phone #

Carrier Address

Policy #	Group / Plan #

Name of Insured (if not same as patient)

DOB of Insured	Relationship to Patient

☐ SECONDARY INSURANCE EXISTS. IF CHECKED, PLEASE INCLUDE INSURANCE INFORMATION ON SEPARATE SHEET.

Physician Information

Testing Authorization

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FOR THIS SERICE TO VITRO MOLECULAR. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO VITRO MOLECULAR OR ANY OF ITS AFFILIATES FRO SERVICES PERFORMED ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT REIMBURSED BY INSURANCE.

PHYSICIAN SIGNATURE **DATE**

PATIENT SIGNATURE **DATE**

Name of Person Completing From	Authorization #

Date of Procedure	ICD-9 Code (required)

Clinical Information (Please click what applies)

Date of LMP: _ _ / _ _ / _ _ _ _

☐ Postmenopausal (year _____)
☐ Pregnant: (weeks ____ _____)
☐ Postpartum: (weeks ____ _____)
☐ HPV Vaccination
☐ Abnormal Bleeding
☐ Suspicious Lesion
☐ IUD
☐ DES Exposure

☐ History of STDs
☐ History of HPV
☐ History of Dysplasia
☐ LSIL ☐ HSIL
☐ Family History of Cervical Cancer
☐ Prior Malignancy

Site: _____

Diagnosis: _____

Hysterectomy:
☐ Subtotal ☐ Total
Date _ _ / _ _ / _ _ _ _

Current Hormone Use:
☐ For Contraception
☐ For Therapy
☐ Estrogen
☐ Progesterone
☐ Estrogen & Progesterone
☐ Other (Specify) _____

☐ Date _ _ / _ _ / _ _ _ _
☐ Bite Biopsy
☐ Colposcopy
☐ Endometrial Biopsy
☐ Cone Biopsy
☐ Cryotherapy
☐ Electrocautery
☐ LEEP
☐ Laser

Previous Pap Smear History (Please check what applies)

DATE	NEGATIVE	UNSAT	ASCUS	ASCH	AGC	LSIL	HSIL	MALIGNANT	HPV

Pap Test

Pap Test Method: ☐ ThinPrep ☐ Sure Path

Test Requested:

☐ Pap test
☐ Pap test w/ High Risk HPV on ASCUS and above
☐ Pap test w/ Reflex High Risk HPV (on ASCUS only for age 20 and over)
☐ Pap test w/ High Risk HPV (for age 30 and over)

Molecular Test:

☐ Chlamydia / Gonorrhea DNA
☐ Chlamydia / Trachomatis DNA
☐ Neisseria Gonorrhea DNA
☐ Reflex to HPV 16/18
☐ Other

Smear Site:

☐ Cervix / Endocervix
☐ Endometrial Aspiration
☐ Labia
☐ Vaginal Vault
☐ Vaginal Wall
☐ Vulva
☐ Anal

	Specimen Source / Procedure	Notes
A	☐ Cervical Bx ☐ ECC ☐ Endometrial Bx ☐ Vulvar Bx ☐ Vaginal Bx ☐ LEEP	
B	☐ Cervical Bx ☐ ECC ☐ Endometrial Bx ☐ Vulvar Bx ☐ Vaginal Bx ☐ LEEP	
C	☐ Cervical Bx ☐ ECC ☐ Endometrial Bx ☐ Vulvar Bx ☐ Vaginal Bx ☐ LEEP	
D	☐ Cervical Bx ☐ ECC ☐ Endometrial Bx ☐ Vulvar Bx ☐ Vaginal Bx ☐ LEEP	
E	☐ Cervical Bx ☐ ECC ☐ Endometrial Bx ☐ Vulvar Bx ☐ Vaginal Bx ☐ LEEP	