Manchester Memorial Hospital
71 Haynes Street
Manchester, CT 06040
860 647-6487

EASTERN CONNECTICUT HEALTH NETWORK, INC.

CYTOPATHOLOGY / DEPARTMENT OF PATHOLOGY

D.G. O'Neill, M.D. **D.S. Patel, M.D.** **M.B. Conlon, M.D.** **R.A. Schwartz, M.D.**

Rockville General Hospital
31 Union Street
Vernon, CT 06066
860 872-5237

PATIENT DATA

PATIENT NAME *(Last)* *(First)* *(M.I.)*	SEX ☐ MALE ☐ FEMALE	ACCESSION NO.
STREET TOWN/CITY STATE ZIP CODE		DATE RECEIVED
SOCIAL SECURITY NO. / AGE / DATE OF BIRTH / PHONE *(HOME)* *(WORK)*		DATE OF COLLECTION

BILLING INFORMATION Please complete below *(a photocopy of the insurance card would be appreciated).*

PRIMARY INSURANCE: NAME / ADDRESS — I.D. # — GROUP #

POLICYHOLDER'S NAME / ADDRESS — RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

POLICYHOLDER'S EMPLOYER / ADDRESS

SECONDARY INSURANCE: NAME / ADDRESS — I.D. # — GROUP #

POLICYHOLDER'S NAME / ADDRESS — RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

MEDICAL RELEASE
I authorize the release of any medical information to process a claim and request payment of any medical insurance benefits to Eastern Connecticut Health Network, Inc. / Eastern Connecticut Pathology Consultants, P.C.

SIGNATURE

MEDICARE PATIENTS - WAIVER OF LIABILITY *(IF APPLICABLE)*
I have been informed that Medicare will not cover yearly Pap testing in my case. I agree to be personally responsible for payment.

SIGNATURE

TO BE COMPLETED BY PHYSICIAN OFFICE

M.D. OFFICE DATA

SOURCE OF SPECIMEN
- ☐ CERVIX / ENDOCERVIX
- ☐ VAGINA
- ☐ NON-GYN (Specify in box below)

TEST REQUESTED (Gyn Cytology)
- ☐ CONVENTIONAL SMEAR
- ☐ LIQUID-BASED PREP
  - ☐ HPV DNA TEST (ASCUS ONLY)
  - ☐ HPV DNA TEST (NEGATIVE OR ASCUS ONLY)
  - ☐ HPV DNA TEST (ANY DIAGNOSIS)
- ☐ GC/CHLAMYDIA

PHYSICIAN

COPY(IES) TO:

GYN CYTOLOGY

LMP (required):

STATUS:

☐ ROUTINE / SCREENING

For Medicare patients, please check below:
- Increased risk for cervical cancer: ☐ YES ☐ NO
- If "NO", and this Pap smear is being performed more frequently than every 2 years, please review and check below:

☐ I have informed the patient that Medicare will not cover yearly Pap testing in her case and have obtained a "signed waiver of liability." (See above)

☐ REPEAT / DIAGNOSTIC
Specify Reason / ICD 9-CM Code:

Increased risk for cervical cancer: ☐ Yes ☐ No
☐ Prenatal ☐ Postpartum

☐ Hysterectomy — ☐ Simple / Total, ☐ Supracervical
☐ Hormone Rx

Comments:

NON-GYN CYTOLOGY
SITE:

CLINICAL DATA / ICD9 CODE:

FOR LAB USE ONLY

LAB DATA

GYN: SPECIMEN ADEQUACY
- ☐ EC COMPONENT
- ☐ SATISFACTORY
- ☐ LIMITED BY _____
- ☐ UNSATISFACTORY _____

GENERAL CATEGORY
- ☐ NILM
- ☐ OTHER
- ☐ ECA
- ☐ NOT GIVEN

NON-GYN:
- ☐ NEGATIVE FOR MALIGNANCY
- ☐ INDETERMINATE FOR MALIGNANCY
- ☐ POSITIVE FOR MALIGNANCY
- ☐ NON-DIAGNOSTIC
- ☐ INSUFFICIENT FOR DIAGNOSIS

SPECIMEN DESCRIPTION:

SCREENED BY: _____ *DATE:* ____/____/____

DESCRIPTIVE DIAGNOSIS / COMMENTS