MAYO CLINIC
Mayo Medical Laboratories

Gyn-Cytology Patient Information Sheet

Patient Name *(Last Name, First Name, Middle Initial)*		Sex ☐ Female ☐ Male
Birth Date *(Month DD, YYYY)*	Collection Date	Collection Time
Physician Name *(Last Name, First Name, Middle Initial)*		Phone

Note: Name must be clearly indicated on the specimen and must match paperwork.

Complete all information below:

Source (select one):	Is Patient (check one)	Last Menstrual Period (LMP)
☐ Cervical/Endocervical ☐ Vaginal	☐ Pregnant ☐ Postpartum ☐ Postmenopausal	____________________ (Month DD, YYYY)
Pertinent Clinical History		

Papanicolaou (PAP) Smear Testing (check one test below)

*Screen			**Diagnostic		
82037	☐	ThinPrep® Pap Screen **without physician interpretation**	82039	☐	ThinPrep® Pap Diagnostic **without physician interpretation**
83342	☐	ThinPrep® Screen with HPV Reflex	83343	☐	ThinPrep® Diagnostic with HPV Reflex
89118	☐	ThinPrep® Screen with HPV co-testing on women greater or equal to 30 years	89119	☐	ThinPrep® Diagnostic with HPV co-testing on women greater or equal to 30 years
8032	☐	Conventional Pap Smear Screen (1 slide) **without physician interpretation**	80184	☐	Conventional Pap Smear Diagnostic (1 slide) **without physician interpretation**

* Screen: Routine Exam. No current symptoms. No previous abnormal finding.
** Diagnostic: Previous abnormal Pap findings, signs or symptoms, or has significant complaints related to female reproductive system. (**describe above)

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