Pelvic Exam / Pap Smear

Client's Name: _____ Date of Exam: _____

Date of Birth: _____

Specimen Type: Conventional _____ Liquid Based _____

Pap Smear sent to:_____ (Lab)

HR HPV DNA (as screening): Yes _____ No_____

Referred for other Pelvic Exams: Yes _____ No _____ Refused _____

Pap Smear Specimen Adequacy: Satisfactory _____
Unsatisfactory for Evaluation _____
Unsatisfactory – specimen not processed _____

Pap Smear Results (ONLY CERVICAL CYTOLOGY CAN BE PAID FOR BY HPMC):

_____ 1. Negative (with normal limits)

_____ 2. Infection/Inflammation/Reactive Changes

_____ 3. A.S.C. – U. S.

Reflex High-Risk HPV testing

___Yes ___No HPV results _____

_____ 4. Low Grade SIL (including HPV changes)

_____ 5. High Grade SIL

_____ 6. Squamous Cell Cancer

_____ 7. Other

_____ 8. A.S.C. - H.

_____ 9. Not Indicated

_____ 10. Indicated but not performed

_____ 11. Pap attempted, no Cervix

_____ 12. A.G.C. - all subcategories

Pelvic Exam Findings:

_____ 1. Suspicious For Cervical Cancer (please describe in comments)

_____ 2. None

_____ 3. Other

_____ 4. Not done-only repeating Pap

Comments: _____
_____
_____

Recommendations for further testing: _____
_____
_____

Recommended date of next exam: _____

Doctor/Practice Name: _____

M.D. Signature: _____ Date: _____

Please include a copy of the Pap Smear Cytology Report from the lab