CANCER SERVICES PROGRAM PELVIC EXAM / PAP SMEAR FORM

Client's Name:____**Date of Exam:** ____________

Date of Birth: ____

Site code | | | | | | |

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 ______________

Provider Risk Assessment for Cervical Cancer

- □ Assessed average risk
- □ Prior DES exposure or Immunocompromised
- □ Risk not assessed
- □ Unknown

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 and FAX to CSP-FLR (585)244-2897****

January 2019