

<input type="checkbox"/> ม.บ. <input type="checkbox"/> อ.ส.	Name and Last name:	<input type="checkbox"/> Female <input type="checkbox"/> Age:	ID. No:
Hospital:		Ward:	HN:
Physician:		LN:	HIS:
			Date&Time of collection:

Gynecologic / PAP REQUISITION FORM

BARCODE

PATHOLOGISTS Prasarn Jimakorn, M.D. Ittee S. Chonmaitri, M.D. Damrong Bhanthumkosol, M.D. Thiti Kuakpaetoon, M.D. Chai Petchasuwan, M.D. Anucha Tangthangtham, M.D. Jidapa Thammasiri, M.D. Sayoomporn Karalak, M.D. Kobkul Tangsinmankong, M.D. Napaporn Puriput, M.D. Paisarn Boonsakan, M.D. Sakchai Chitpakdee, M.D. Piriya Sutthiruangwong, M.D. Anchaleerat Lertsatit, M.D. Thiwaporn Thesawadwong, M.D. Weena Laddachayaporn, M.D. Poonnawis Sudtikoonaseth, M.D. Chutima Chavanisakun, M.D. Nisarath Dhanarak, M.D. Noppadol Larbcharoensub, M.D. Churaion Unhasuta, M.D.	<input type="checkbox"/> Conventional Pap smear [No. of slides.....]						
	<table border="1"> <tr> <th>Liquid-Based Cytology</th> <th>Molecular Cytology</th> <th>Others (specify)</th> </tr> <tr> <td> <input type="checkbox"/> ThinPrep Pap Test <input type="checkbox"/> Liqui-Prep Pap Test <input type="checkbox"/> CYPREP Pap Test </td> <td> <input type="checkbox"/> APTIMA HPV (HPV HR & HPV 16/18,45 Testing) <input type="checkbox"/> Cobas HPV [HPV PCR 14 HR Typing (16/18/12 other HR)] </td> <td></td> </tr> </table>	Liquid-Based Cytology	Molecular Cytology	Others (specify)	<input type="checkbox"/> ThinPrep Pap Test <input type="checkbox"/> Liqui-Prep Pap Test <input type="checkbox"/> CYPREP Pap Test	<input type="checkbox"/> APTIMA HPV (HPV HR & HPV 16/18,45 Testing) <input type="checkbox"/> Cobas HPV [HPV PCR 14 HR Typing (16/18/12 other HR)]	
	Liquid-Based Cytology	Molecular Cytology	Others (specify)				
	<input type="checkbox"/> ThinPrep Pap Test <input type="checkbox"/> Liqui-Prep Pap Test <input type="checkbox"/> CYPREP Pap Test	<input type="checkbox"/> APTIMA HPV (HPV HR & HPV 16/18,45 Testing) <input type="checkbox"/> Cobas HPV [HPV PCR 14 HR Typing (16/18/12 other HR)]					
	SOURCE OF SPECIMEN: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical <input type="checkbox"/> Endometrial <input type="checkbox"/> Scraping/ direct smear, vulva <input type="checkbox"/> Others						
	Clinical Dx: <input type="checkbox"/> Check up <input type="checkbox"/> Leukorrhea <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Postpartum <input type="checkbox"/> Others						
	Pertinent Clinical Hx: <input type="checkbox"/> Menopause.....yr. <input type="checkbox"/> TAH <input type="checkbox"/> LTH <input type="checkbox"/> VH <input type="checkbox"/> BSO <input type="checkbox"/> LSO <input type="checkbox"/> RSO <input type="checkbox"/> Other-specify: Para Last LMP						
	Previous treatment (specify): <input type="checkbox"/> Hormones <input type="checkbox"/> Radiation <input type="checkbox"/> IUD Others						
	Clinical Dx: / Clinical findings:						
	Previous PAP or surgical no. and/or result <input type="checkbox"/> Yes Result Date <input type="checkbox"/> No						
Physician's Signature M.D. Date.....							
For BPL used only No. of slides No. of bottles Received date and time Registration date and time							