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REFERRAL REQUEST - PAP TEST

Patient Information

Name:
Date of Birth:
HCN:
Phone Number:
Address:

Referring HCP

Name:
Billing #:
Fax:

LMP: _____

Prior Pregnancies: G ___ T ___ P ___ A ___ L ___

Last Pap test date: _____

Normal/Abnormal? (Please circle one)

Comments: _____

You will be provided with a report and consult note.
If your patient is part of a FHT/FHO model, there will be no negation.