



KAISER PERMANENTE®

Colorado Region -Regional Reference Laboratory
Cytology Department 303-404-4160 FAX: (303) 404-4161
11000 E. 45th Avenue
Denver, CO 80239

**COMMUNITY PROVIDER & DOWNTIME FORM
PAP or NonGYN & FNA REQUEST**

(Use for LIS-HealthConnect unavailable or Non-KP Provider Only)

Order Date: _____ **Facility & Clinic:** _____

***Patient Name:** _____ ***KP ID#** _____

***Non-KP/Community Provider**

KP Provider

***Provider Name:** _____

***Provider Address:** _____

***Provider FAX number:** _____ ***Phone No.:** _____

PLEASE ATTACH OUTSIDE CLINIC SPECIMEN ORDERS

Patient Date of Birth: _____ **LMP** _____

***Source (be specific):** _____

*****Please write the source/site on the container(s).*****

Sources/sites must match for specimen to be accepted by KP Labs.

Pap Only HPV-Cotest for 30-65 year old ChlamGc HPV Only -No Pap

Clinical History: _____

Clinical Diagnosis (ICD-10): _____

Previous Cytology/Biopsy: _____

Lab Use only

Case Number: _____ **Number of Slides:** _____

Pathologist: _____ **Containers Recvd:** _____