Central Oregon Pathology CONSULTANTS

TEST ADD-ON FORM

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____

COPC ACCESSION #: _____

COLLECTION DATE: _____

TESTING

- ☐ HIGH RISK HPV
- ☐ HPV 16/18 GENOTYPING

CLINICIAN INFORMATION

ORDERING PHYSICIAN: _____

CLINIC NAME: _____

DATE ORDERED: _____

AUTHORIZED SIGNATURE: _____

PLEASE RETURN WITH YOUR PATHOLOGY COURIER
Or
FAX TO 541-389-5723

State and Federal laws require written verification of all laboratory and pathology test add-ons