nova scotia health authority

Department of Pathology and Laboratory Medicine - Central Zone

Cytology Requisition: Gynecological

Please label the frosted end of all slides using pencil. Include patient's full name and health card number or another unique identifier.

Gray fields indicate required information to prevent delay or rejection of sample.

Time stamp (for lab use only):

# of slides received: _____

Authorized requestor's information:

Ordering clinician/practitioner _____

PRN (Physician registration #) _____

Address _____

Telephone (for critical results) (_____) _____ - _____

Copy to clinician/practitioner name _____

PRN _____ Location _____

Copy to clinician/practitioner name _____

PRN _____ Location _____

Patient's information:

Name _____ Last _____ First _____ Middle

Full address _____ Street

_____ City/Town _____ Province _____ Postal code

HCN (Health card #) _____

Health card province _____ Expiry date _____ YYYY / MM / DD

Unique identifier # _____ (if HCN is not available) Type _____ (see reverse)

Date of birth _____ YYYY / MM / DD ☐ Male ☐ Female

Telephone (_____) _____ - _____ *(12 hours from collection)*

Third party billing: ☐ Workers' Compensation Board (WCB)

☐ Other: _____ Name (research account (SAP), self-pay, etc.)

Collected by signature _____ ID # _____ (from Capital Health)

Date collected _____ YYYY / MM / DD Time _____ (24-hour clock) hrs

Authorized requestor's signature _____ Date signed _____ YYYY / MM / DD

Gynecological specimens (please print clearly)

Please provide all requested information to avoid delays in processing:

Smear site: ☐ Cervical ☐ Vaginal ☐ Endocervix **Date of LMP:** _____ YYYY / MM / DD **Weeks pregnancy/post partum:** _____

BCP: ☐ N ☐ Y **IUD:** ☐ N ☐ Y **Menopause:** ☐ N ☐ Y **Regular menstrual cycle:** ☐ N ☐ Y

Please select relevant clinical history:

☐ Colposcopy done at present Pap

☐ Abnormal bleeding in postmenopausal woman

☐ Abnormal bleeding in woman with hysterectomy

☐ Abnormal bleeding in woman over 50 years

☐ Postcoital bleeding

☐ Gynecological malignancy (untreated) / obvious Ca.

☐ Suspicious, reddened, or friable cervix

☐ Previous abnormal with no indication of patient management

☐ Other gynecological abnormality – specify: _____

_____

☐ Condyloma/HPV/genital warts

☐ Infertility assessment

THERAPY/PROCEDURE	YEAR
☐ Hormone (e.g. HRT)	_____
☐ Radiation	_____
☐ Chemotherapy	_____
Hysterectomy: ☐ Total	_____
☐ Partial	_____

PREVIOUS	YEAR	DIAGNOSIS
☐ Colposcopy	_____	_____
☐ Punch biopsy	_____	_____
☐ Cone biopsy/LEEP	_____	_____

Clinical comments (please print clearly):

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Time stamp (for lab use only):

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Cytology Requisition: Non-Gynecological

Gray fields indicate required information to prevent delay or rejection of sample.

Authorized requestor's information:

Ordering clinician/practitioner

PRN (Physician registration #)

Address

Telephone (for critical results) ( ) -

Copy to clinician/practitioner name

PRN Location

Copy to clinician/practitioner name

PRN Location

Patient's information:

Name Last First Middle

Full address Street

City/Town Province Postal code

HCN (Health card #)

Health card province Expiry date YYYY / MM / DD

Unique identifier # (if HCN is not available) Type (see reverse)

Date of birth YYYY / MM / DD ☐ Male ☐ Female

Telephone ( ) - *(12 hours from collection)*

Third party billing: ☐ Workers' Compensation Board (WCB)

☐ Other: Name (research account (SAP), self-pay, etc.)

Collected by signature ID # (from Capital Health)

Date collected YYYY / MM / DD Time (24-hour clock) hrs

Authorized requestor's signature Date signed YYYY / MM / DD

Non-gynecological specimens (please print clearly)

Please provide all requested information to avoid delays in processing:

Priority: ☐ Urgent ☐ Routine

Previous cytology: ☐ N ☐ Y

Date of specimen: YYYY / MM / DD

Prior malignancy: ☐ N ☐ Y – specify site:

Non-gynecological specimen type:

☐ Voided urine

☐ Cystoscopic urine

☐ Catheterized urine

☐ Common bile duct brushing

Bronchial washing: ☐ Right ☐ Left

Bronchial brushing: ☐ Right ☐ Left

Pleural fluid: ☐ Right ☐ Left

Peritoneal fluid: ☐ Right ☐ Left

☐ Peritoneal washing

☐ CSF

☐ Fine needle aspiration – specify source:

☐ Other – specify source:

Clinical history:

Radiological findings:

Clinical diagnosis:

FOR LAB USE ONLY

Tech Amt ☐ Brush present

Color ☐ Cytolyt Other fixative

☐ Transparent ☐ Translucent ☐ Opaque

☐ Mucinous ☐ Bloody Sediment

☐ Dilute ☐ Cell block ☐ DTT

Specimen source

Specimen description

Called submitting location