DynaLIFE MEDICAL LABS

GYNECOLOGIC CYTOPATHOLOGY REQUISITION

*Dyna***LIFE** Medical Labs 1 (800) 661-9876 or (780) 451-3702
Alberta Public Laboratories 1 (877) 868-6848

Scanning Label or Accession # *(lab only)*

Patient

PHN / Healthcare Number Expiry:_____	Alternate Identifier		Date of Birth *(dd-Mon-yyyy)*
Legal Last Name	Legal First Name		Middle Name
Preferred Name	☐ Male ☐ Female ☐ X (Non-Binary/Prefer not to Disclose)		Phone
Address	City / Town	Province	Postal Code

Provider(s)

Authorizing Provider Name *(Last, First, Middle)* Nurse, Jane	Authorizing Provider Name *(Last, First, Middle)*	Authorizing Provider Name *(Last, First, Middle)*
Address Garden River Nursing Station, Garden River T0H 4G0	Address	Address
Provider ID: **987654** / Submitter ID: **123456** / Phone: **780 659 3131**	Phone	Phone
Clinic / Building Name	Clinic / Building Name	Clinic / Building Name

Copy To 1 **Copy To 2**

Collection

Date *(dd-Mon-yyyy)*	Time *(24h)*	Location	Collector ID

Each specimen container MUST be labelled with the following:

- **Patient First and Last Name**
- **PHN / Healthcare Number**
- **Specimen Type (Source)**

Date / Time Received:

SPECIMEN SITE

☐ **Cervix** ☐ **Vagina**

CLINICAL INFORMATION (please print clearly)

LMP: | | | | | | | | | |
D D M M M Y Y Y Y

HPV Immunization Series Completed: ☐ Yes ☐ No

☐ Hysterectomy (Cervix removed)
☐ Hysterectomy (Cervix intact)
☐ IUD
☐ Pregnant
☐ Post-partum
☐ Menopausal
☐ Immunocompromised
☐ First Pap following discharge from Colposcopy

RELEVENT CLINICAL HISTORY

COLPOSCOPY CLINIC ONLY

☐ First Colposcopy visit
☐ Pap taken at Colposcopy

IMPRESSION: ☐ Negative ☐ HPV / LSIL ☐ HSIL