CYTOLOGY & HPV TESTING REQUISITION

CLEAR FORM

LifeLabs® Medical Laboratory Services

Laboratory Use Only

Requesting Clinician/Practitioner

Name

Address

Clinician/Practitioner Billing Number

Clinician/Practitioner Phone Number | Patient Chart Number

Health Card Number (HCN) | Version | Sex ☐ M ☐ F | Date of Birth YYYY MM DD

Copy to Clinician(s)/Practitioner(s) *(fill in all fields):*

Name Billing #

Address

Name Billing #

Address

Province | Other Province's Registration Number | Patient Phone Number

Patient Last Name *(as per Health Card)*

Patient First Name & Middle Names *(as per Health Card)*

Patient Address *(including postal code)*

GYNECOLOGIC CYTOLOGY (PAP TEST)

Clinical Indication *(check one)*:

- ☐ Pap screening according to Ontario Cervical Screening Guidelines
- ☐ Pap for follow-up of a previous abnormal test result *(specify below)*
- ☐ Pap during colposcopic exam
- ☐ Patient Pay *(none of the above; the patient has been informed that payment to LifeLabs is required.)*

Specimen Collection Date: YYYY MM DD

Last Menstrual Period *(first day):* YYYY MM DD

Site: ☐ Cervical/Endocervical ☐ Vaginal ☐ Other *(specify below)*

Cervix: ☐ Normal ☐ Abnormal *(specify below in Clinical History/Remarks)*

Clinical Status:

- ☐ Pregnancy
- ☐ Post Partum
- ☐ Post Menopausal
- ☐ Post Menopausal Bleeding
- ☐ IUD
- ☐ Hormone Replacement Therapy
- ☐ Irradiation
- ☐ Other *(specify below in Clinical History/Remarks)*

Hysterectomy: ☐ Sub-total (cervix present) ☐ Total (no cervix)

HPV TESTING

☐ **HPV Testing** *(High Risk only - no genotyping available)*
(The patient has been informed that payment to LifeLabs is required.)

Specimen Collection Date: YYYY MM DD

NON-GYNECOLOGIC CYTOLOGY

☐ OHIP/Insured ☐ Third Party/Uninsured ☐ WSIB

Specimen Collection Date: YYYY MM DD

# of Specimens Submitted | # of Slides Submitted

Urine: ☐ Voided ☐ Catheterized ☐ Bladder Wash

Respiratory: ☐ Sputum ☐ Bronchial Brush ☐ Bronchial Wash

Site/Side *(if applicable):*

Fluids: ☐ Pleural ☐ Peritoneal ☐ CSF ☐ Other *(specify)*

Site/Side *(if applicable):*

Thyroid: ☐ Left ☐ Right ☐ Cyst ☐ Nodule ☐ Single ☐ Multiple

Breast: ☐ Left ☐ Right ☐ Cyst fluid ☐ FNA of Mass ☐ Nipple Discharge

Fine Needle Aspiration Biopsy: ☐ Left ☐ Right

- ☐ Kidney
- ☐ Salivary Gland
- ☐ Lung
- ☐ Liver
- ☐ Lymph Node *(specify)*
- ☐ Pancreas
- ☐ Other *(specify):*

Other Site *(specify):*

Clinical History/Remarks:

Inadequate clinical information may hinder diagnosis. For accurate and timely cytologic diagnosis, provide all information required.

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PRINT FORM

XXX-FORMCYTO (04/13)