Western Health

CYTOLOGY #: NG_____

CYTOLOGY FOR NON-GYNE REQUISITION

(Fields marked with an * are Mandatory)

Form# 12-5020

*DATE & TIME COLLECTED	SIGNATURE OF SENDER	DATE & TIME RECEIVED	SIGNATURE OF RECEIVER
/ / _____hrs (DD MM YYYY)		/ / _____hrs (DD MM YYYY)	

LOCATION/WARD: .....

*PATIENT NAME: ..... (LAST)

..... (FIRST)

*DATE OF BIRTH: ..... SEX: ☐ M ☐ F (DD/MM/YYYY)

CHART #: .....

*MCP#: .....

*TYPE & SOURCE OF SPECIMEN: .....

ABNORMAL BLEEDING OR DISCHARGE: ☐ Yes ☐ No

PREVIOUS SURGERY: .....

*NAME OF ORDERING PHYSICIAN:

PRINT LEGIBLY ..... (LAST)

..... (FIRST)

Copy of report to: .....

Address: .....

.....

Phone: .....

Fax: .....

PLEASE COMPLETE THE INFORMATION ABOVE, PRINT CLEARLY

Specimens may not be examined without the appropriate Demographics and Clinical Information

CLINICAL DIAGNOSIS/HISTORY:

_____ *PHYSICIAN SIGNATURE

_____ *DATE (DD/MM/YYYY)

FOR CYTOLOGY USE ONLY - DO NOT WRITE BELOW

☐ NO MALIGNANT OR DYSPLASTIC CELLS SEEN ☐ ABNORMAL (SEE BELOW) ☐ UNSATISFACTORY (SEE BELOW)

DATE REPORTED: _____ (DD/MM/YYYY) PATHOLOGIST: _____

PHYSICAL APPEARANCE: _____

☐ NO MALIGNANT OR DYSPLASTIC CELLS _____

☐ ABNORMAL _____

☐ UNSATISFACTORY _____

☐ CB ☐ LBC ☐ SMEAR DATE REPORTED: _____ (DD/MM/YYYY) CYTOTECH: _____

Revised March 24, 2016