

DIAGNOSTIC CYTOLOGY REQUISITION

NOTE: Each specimen/part type must have a separate fully completed requisition.
All specimens, requisitions and slides must be labelled.
Lack of/or unclear information will result in a delay or failure of processing.
PHSA Labs are not responsible for unlabelled specimens.

Specimen Collection Date\Time		Number Of Slide(s) FIXED
RUSH	Specimen Fixed: <input type="checkbox"/> No <input type="checkbox"/> Yes	Number Of Slide(s) UNFIXED
<input type="checkbox"/>	Type of Fixative:	

Respiratory

SPECIMEN TYPE:

- SPUTUM Specific Lobe
- BRONCHIAL WASH L R _____
- BRONCHIAL BRUSH L R _____
- BRONCHOALVEOLAR LAVAGE L R _____
- EBUS Lymph Node SPECIFY SITE: _____
- LUNG FNA SPECIFY LOBE: _____

Urinary

- URINE - VOIDED ILEAL CONDUIT
- URINE - CATHETERIZED URETER L R
- URINE - CYSTOSCOPY RENAL PELVIS L R
- OTHER SPECIFY SITE: _____

Fluids

- CEREBROSPINAL FLUID
- PLEURAL FLUID L R
- PERITONEAL FLUID WASH
- PERICARDIAL FLUID
- JOINT FLUID L R SPECIFY SITE: _____

Fine Needle Aspirate

- BREAST L R SPECIFY SITE: _____
- THYROID L R Isthmus
- OTHER L R SPECIFY SITE: _____

MISCELLANEOUS

- ANAL - RECTAL
- NIPPLE DISCHARGE L R
- OTHER SPECIFY SITE: _____

PATIENT DEMOGRAPHICS

Enter data manually, addressograph, or affix label

NAME (LAST)

NAME (FIRST)

BIRTH DATE (DD/MM/YYYY)

CARE CARD NUMBER (PHN)

MRN NUMBER

SEX M F OTHER Specify

Send Reports To: Doctor MSC#

Doctors Name and Address: Office, Clinic or Hospital

Send Copy To:

MSC# _____ Name: _____

MSC# _____ Name: _____

MSC# _____ Name: _____

Previous Malignancy: YES NO

DATE: _____ TYPE: _____

CLINICAL DATA: Radiation Therapy: DATE: _____

Chemotherapy: DATE: _____

CLINICAL INFORMATION:

Adequate clinical information is essential for accurate cytological interpretation.

LAB USE ONLY:

PAP <input type="checkbox"/>	MGG <input type="checkbox"/>	REQUISITION LABEL
OTHER <input type="checkbox"/>	CB <input type="checkbox"/>	
THIN <input type="checkbox"/>	TOTAL <input type="checkbox"/>	