NL Health Services

CL2150 0009 05 2019

HCN: _____

Province/Territory: _____ Expiry: DD/MM/YYYY

Name: _____

Date of Birth: DD/MM/YYYY Sex: ☐ M ☐ F ☐ UN

Mailing Address: _____

City: _____

Province/Territory: _____ Postal Code: _____

Telephone: (Indicate Preferred): ☐ Home: _____

☐ Cell: _____ ☐ Work: _____

Cervical Cancer Screening Requisition

Ordering Provider's Name: _____ Clinic Name: _____ Mailing Address: _____ City: _____	**Clinic Stamp**:(include fax, provider and mnemonics)
Province/Territory: _____ Postal Code: _____ Telephone: _____ Fax: _____ Signature: _____ Date: DD/MM/YYYY	Ordering Provider's Meditech Mnemonic: _____ EMR Clinic Mnemonic: _____ COPY TO PROVIDER _____
Date Specimen Collected: DD/MM/YYYY Time: HH:MM	Source of Specimen: ☐ Cervical/Endocervical ☐ Vaginal

Indicate test required (check one only):

☐ HPV DNA Panel (HPV - Human Papillomavirus)

☐ Pap Smear

☐ Co-Testing (Order both HPV DNA Panel and Pap Smear. Restricted to symptomatic patients suggestive to cervical abnormalities **OR** colposcopy patients with history of high-grade cytology/histology only)

Clinical History:

Post-Menopausal: ☐ Yes ☐ No (If No, last menstural period (LMP) mandatory) LMP date: DD/MM/YYYY

Hysterectomy: ☐ Total (cervix removed) ☐ Subtotal (cervix retained) ☐ No

Abnormal Bleeding: ☐ Yes ☐ No

Previous Abnormal Pap/Colposcopy: ☐ Yes ☐ No Specify: _____

HPV Vaccination: ☐ Yes ☐ No

Previous Pap Smear: ☐ Yes ☐ No If Yes, date: DD/MM/YYYY

Medications:

☐ Birth Control Pill ☐ Hormone Replacement Therapy ☐ Chemotherapy/Radiation ☐ Depo-Provera
☐ Intrauterine Device

Other Significant History/Colposcopic Findings:

Laboratory Use Only

Lab Accession Number: _____

Technologist/Pathologist Name: _____ Signature: _____ Date: DD/MM/YYYY

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