Eastern Health

Laboratory Medicine

Cytology Non-Gyn Specimen Requisition

IV2260 1357 06 2015

Name:

HCN:

Date of Birth:

PLEASE COMPLETE FORM LEGIBLY

1 PHYSICIAN`S FULL NAME:_____ PHYSICIAN`S ADDRESS:_____

2 PHYSICIAN`S FULL NAME:_____ PHYSICIAN`S ADDRESS:_____

TYPE/SOURCE OF SPECIMEN: _____ GENDER: ☐ MALE ☐ FEMALE

DATE AND TIME OF SPECIMEN COLLECTION: DD/MONTH/YYYY

Clinical Impression/Findings and Patient History: (Including previous su rgery, medications , treatment)

NAME:_____ SIGNATURE:_____ DATE:DD/MONTH/YYYY

LABORATORY USE ONLY

(Affix Cytology Accession Label Here)

SPECIMEN DESCRIPTION: _____

SLIDE PREPARATION:

LIQUID BASED

Number Liquid Based Slides: _____

CELL BLOCK: ☐ YES ☐ NO

CELL BUTTON:_____

CONVENTIONAL (Direct Smears)

Number Diff-Quik Slides:_____ Number Pap Slides: _____

CELL BLOCK PREPARED IN FORMALIN: ☐ YES ☐ NO

CELL BUTTON: _____

CYTOTECHNOLOGIST:

☐ SATISFACTORY ☐ UNSATISFACTORY

☐ NO MALIGNANT CELLS SEEN ☐ ABNORMAL

COMMENTS: _____

CYTOTECHNOLOGIST'S NAME: _____

CYTOTECHNOLOGIST'S SIGNATURE: _____

DATE REPORTED:DD/MONTH/YYYY

PATHOLOGIST:

☐ SATISFACTORY ☐ UNSATISFACTORY

☐ NO MALIGNANT CELLS SEEN ☐ ABNORMAL

COMMENTS: _____

PATHOLOGIST'S NAME: _____

PATHOLOGIST'S SIGNATURE: _____

DATE REPORTED:DD/MONTH/YYYY