North Bay Regional Health Centre

Laboratory
Cytology & HPV Testing Requisition

Patient Address:

Submitting Physician/Practitioner:

Specimen Collected by:

Copy to *(include address if health care provider is not from the area)*:

Physician Signature:

Location *(specimen collection site)*:

NBRHC *(choose one):*
- ☐ Diagnostic imaging
- ☐ Emergency
- ☐ OR
- ☐ Floor *(specify below)*
- ☐ Clinic *(specify below)*
- ☐ Other *(specify below)*

OFF SITE *(choose one):*
- ☐ Dr/NP Office *(specify below)*
- ☐ Clinic *(specify below)*
- ☐ Other *(specify below)*

_____

For NBRHC cytology lab label ↓

For GYN HPV testing label ↓

GYNECOLOGICAL Cytology (PAP TEST)

Clinical Indication *(check one):*
- ☐ Pap according to Ontario Cervical Screening Guidelines
- ☐ Pap for follow-up of a previous abnormal test result *(specify in "**Clinical Data**" above)*
- ☐ Pap during colposcopic exam
- ☐ Patient Pay *(none of the above; the patient has been informed that payment to NBRHC is required.)*

Specimen Collection Date _____(dd/mm/yyyy)

Last Menstrual Period *(first day):* _____ (dd//mm/yyyy)

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

Cervix: ☐ Normal ☐ Abnormal *(specify in "**Clinical Data**")*

Clinical Status:

- ☐ Pregnancy
- ☐ Post Partum
- ☐ Post Menopausal
- ☐ Post Menopausal Bleeding
- ☐ IUD
- ☐ Hormones *(specify in "**Clinical Data**")*
- ☐ Irradiation
- ☐ Other *(specify in "**Clinical Data**")*

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

HPV Testing *(Referred out testing)*

☐ **HPV Testing**
○ *Patient is informed that payment at the NBRHC OP lab is required*

Specimen Collection Date _____ (dd/mm/yyyy)

NON-GYNECOLOGICAL Cytology

Specimen Collection Date: _____ (dd/mm/yyyy)

Time: _____

_____ # of Specimens Submitted _____# of Slides Submitted

Respiratory
- ☐ Sputum
- ☐ Bronchus:
  ☐R _____☐L _____
  Wash ___ Brush ___

Fine Needle Aspiration *(specify anatomical site)*
☐R ☐L
_____
_____
_____

Body Fluid
- ☐ Peritoneal Fluid
- ☐ Pelvic Wash
- ☐ Pleural Fluid *(specify):* ☐R ☐L
- ☐ Joint *(specify):* _____
- ☐ Cyst *(specify):* _____
- ☐ CSF
- ☐ Other *(specify):* _____

Urinary
- ☐ Urine *(specify):*
  ☐ Voided
  ☐ Catheterized
  ☐ Cystoscopic
- ☐ Ureter: ☐R ☐L
  Wash ___ Brush ___
- ☐ Renal: ☐R ☐L
  Wash ___ Brush ___
- ☐ Bladder Wash

Direct Smear
- ☐ Nipple Discharge *(specify):* ☐R ☐L
- ☐ Other *(specify):*

_____
_____
_____

Clinical Data/History/Remarks:

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