RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Cytology Requisition

Fredericton and Upper River Valley Area

• Laboratory #	LAST NAME (PLEASE PRINT)	FIRST NAME	MAIDEN/OTHER NAME	
RECEIVED DATE/TIME	DATE of BIRTH (day/month/year)	MEDICARE #	HOSPITAL #	SEX
❑ INPATIENT ❑ OUTPATIENT ❑ NON-RESIDENT	ORDER DOCTOR/ NURSE PRACTIONER	COPIES TO	LOCATION	
❑ THIRD PARTY BILLING	COLLECTED DATE (day/month/year): / /	TIME		

HISTORY AND CLINICAL INFORMATION

GYNECOLOGICAL SPECIMENS

All slides submitted for assessment MUST have the patient's full name and medicare number PRINTED in PENCIL on the frosted end of the slide(s).

DATE OF LMP (day/month/year): / /

SPECIMEN SOURCE	CONTRACEPTION	MENSTRUAL STATUS	THERAPY
❑ Endocervical	❑ Oral	❑ Pregnant ______ weeks	❑ HormoneReplacement
❑ Cervical	❑ Depoprovera	❑ Post Partum ______ weeks	❑ Chemotherapy
❑ Vaginal Pool	❑ IUD		❑ Radiation
❑ Vaginal Vault	❑ Other (specify):	❑ Hysterectomy-total	❑ Other (specify):
❑ Endometrial		❑ Hysterectomy-sub-total	
		❑ Menopausal	*FOR LAB USE ONLY*
		❑ Post Menopausal	# Slides

NON-GYNECOLOGICAL SPECIMENS

All slides submitted for assessment MUST have the patient's full name and medicare number PRINTED in PENCIL on the frosted end of the slide(s).

SPECIMEN TYPE	FLUID	FINE NEEDLE ASPIRATION
❑ Voided Urine	❑ Pleural	❑ Breast
❑ Cystoscopic Urine	❑ Peritoneal	❑ Liver
❑ Catheterized Urine	❑ Pericardial	❑ Lymph Node
❑ Sputum	❑ Synovial	❑ Lung
❑ Bronchial Washing		❑ Mediastinum
❑ Bronchial Brushing	**CYST ASPIRATION**	❑ Neck
❑ Esophageal Brushing	❑ Specify	❑ Ovary
❑ Pelvic Washing	Site	❑ Pancreas
❑ Gutter Washing		❑ Kidney
❑ Cul-de-sac Fluid	**OTHER SPECIMEN**	❑ Retroperitoneum
❑ Nipple Discharge	❑ Specify	❑ Salivary Gland
❑ Cerebral Spinal Fluid	Site	❑ Thyroid
		❑ Other FNA (Specify)

❑ **SPECIMEN REJECTED**

REASON:

FOR LAB USE ONLY	
# Submitted Slides	# Lab Prepared Slides
❑ Filter	❑ Cell Block Slides
❑ Centrifuge/ Cytospin	❑ I ❑ O ❑ R
Gross Description	
Lab Comment	