

# CYTOLOGY & HPV TESTING REQUISITION



Requesting Clinician/Practitioner

Name

Address

Clinician/Practitioner Billing Number

Copy to Clinician(s)/Practitioner(s) (fill in all fields):  
Name Billing #

Address

Name Billing #

Address

Laboratory Use Only

Clinician/Practitioner Phone Number

Patient Chart Number

Health Card Number (HCN)

Version

Sex  M  F

Date of Birth

YYYY | MM | DD

Province

Other Province's Registration Number

Patient Phone Number

Patient Last Name (as per Health Card)

Patient First Name & Middle Names (as per Health Card)

Patient Address (including postal code)

## GYNECOLOGIC CYTOLOGY (PAP TEST)

**Clinical Indication (check one):**

- Pap screening according to Ontario Cervical Screening Guidelines
- Pap for follow-up of a previous abnormal test result (specify below)
- Pap during colposcopic exam
- Patient Pay (none of the above; the patient has been informed that payment to LifeLabs is required.)

**Specimen Collection Date:** YYYY | MM | DD

**Last Menstrual Period (first day):** YYYY | MM | DD

**Site:**  Cervical/Endocervical  Vaginal  Other (specify below)

**Cervix:**  Normal  Abnormal (specify below in Clinical History/Remarks)

**Clinical Status:**

- Pregnancy  Post Partum
- Post Menopausal  Post Menopausal Bleeding
- IUD  Hormone Replacement Therapy
- Irradiation  Other (specify below in Clinical History/Remarks)

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

## HPV TESTING

- HPV Testing (High Risk only - no genotyping available)  
(The patient has been informed that payment to LifeLabs is required.)

**Specimen Collection Date:** YYYY | MM | DD

**Clinical History/Remarks:**

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

## NON-GYNECOLOGIC CYTOLOGY

- OHIP/Insured  Third Party/Uninsured  WSIB

**Specimen Collection Date:** YYYY | MM | DD

..... # of Specimens Submitted ..... # of Slides Submitted

**Urine:**  Voided  Catheterized  Bladder Wash

**Respiratory:**  Sputum  Bronchial Brush  Bronchial Wash

Site/Side (if applicable): .....

**Fluids:**  Pleural  Peritoneal  CSF

Other (specify) .....

Site/Side (if applicable): .....

**Thyroid:**  Left  Right  
 Cyst  Nodule  Single  Multiple

**Breast:**  Left  Right  
 Cyst fluid  FNA of Mass  Nipple Discharge

**Fine Needle Aspiration Biopsy:**  Left  Right  
 Kidney  Salivary Gland  Lung  
 Liver  Lymph Node (specify)  Pancreas  
 Other (specify): .....

**Other Site (specify):** .....

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