

For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

CERVICAL CYTOLOGY REQUEST FORM



Send specimen to:

- Gamma Dynacare Medical Laboratories**
 830 King Edward St, Ste #100, Winnipeg, MB R2H 0P4
 Ph: (204) 944-0757 Fax: (204) 957-1221
- Health Sciences Centre Cytology Laboratory**
 820 Sherbrook St (MS337), Winnipeg, MB R3A 1R9
 Ph: (204) 787-1352 Fax: (204) 787-1790
- Westman Laboratory**
 Unit I-150 McTavish Ave, E, Brandon, MB R7A 7H8
 Ph: (204) 578-4440 / 1-800-661-5458 Ext. 4467
 Fax: (204) 578-2819
- St. Boniface Hospital Cytology Laboratory**
 409 Taché, Winnipeg, MB R2H 2A6
 Ph: (204) 237-2504 Fax: (204) 235-3423
- Unicity Laboratory Services, Cytology Department**
 106-2200 McPhillips St, Winnipeg, MB R2V 3P4
 Ph: (204) 633-2806 Fax: (204) 632-9236

Accession #

Date received (dd/mmm/yyyy)

Specimen collection date (dd/mmm/yyyy)

PATIENT INFORMATION
 * Matching PHIN and first and last name required on vial (or slide in pencil)

.....

Last name First name

.....

PHIN (or military, other prov/terr #) MB Health #

.....

F M

Date of birth (dd/mmm/yyyy) Gender 3rd party billing

.....

Address

.....

City Prov Postal code

PATIENT HISTORY

.....

Last normal menses (dd/mmm/yyyy) Last Pap test (dd/mmm/yyyy)

.....

Previous abnormal Pap test (dd/mmm/yyyy)

Pregnant Postpartum ____ (# weeks)

Menopausal Postmenopausal

PREVIOUS TREATMENT:

Colposcopy Laser Cryotherapy LEEP

Knife cone Irradiation Wide local excision

.....

Date (dd/mmm/yyyy)

HYSTERECTOMY: Previous cancer

Total Subtotal

PRESENT TREATMENT:

Hormonal: HRT OCP IUCD

COMMENTS:

.....

SPECIMEN PREPARATION:

Liquid based cytology Conventional cytology

INSTRUMENT(S):

Broom Spatula Cytobrush

SOURCE:

Cervix Vagina

PROVIDER INFORMATION

.....

Last name First name

.....

CervixCheck/Provider # Bill to (#)

.....

Send report to (street address)

.....

City/Town Prov Postal code

.....

Phone Fax

.....

Copy report to (name)

.....

Address

DESIGNATION:

Physician Nurse practitioner Nurse

Physician assistant Clinical assistant Midwife

Providers should identify themselves on the form as follows:

DESIGNATION	CERVIXCHECK/PROVIDER #:	BILL TO (#):
Clinical assistant	22### (CervixCheck provider #)	Physician or NP billing #
Midwife	M6### (Midwife provider #)	Midwife billing #
Nurse practitioner	Not applicable	Billing #
Nurse (RN, LPN)	N### (CervixCheck provider #)	Physician or NP billing #
Physician	Not applicable	Billing #
Physician assistant	72### (CervixCheck provider #)	Physician or NP billing #