CERVICAL CYTOLOGY REQUEST FORM

CervixCheck
CancerCare Manitoba

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

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

SPECIMEN PREPARATION:
☐ Liquid based cytology ☐ Conventional cytology

INSTRUMENT(S):
☐ Broom ☐ Spatula ☐ Cytobrush

SOURCE:
☐ Cervix ☐ Vagina

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:
☐ Total ☐ Subtotal

Previous cancer

PRESENT TREATMENT:
Hormonal: ☐ HRT ☐ OCP ☐ IUCD

COMMENTS:

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 #