

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)

<b>PATIENT INFORMATION</b>		
* 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 #	
Date of birth (dd/mmm/yyyy)	Gender <input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> 3 <sup>rd</sup> party billing
Address		
City	Prov	Postal code

<b>PATIENT HISTORY</b>	
Last normal menses (dd/mmm/yyyy)	Last Pap test (dd/mmm/yyyy)
Previous abnormal Pap test (dd/mmm/yyyy)	
<input type="checkbox"/> Pregnant <input type="checkbox"/> Postpartum _____ (# weeks) <input type="checkbox"/> Menopausal <input type="checkbox"/> Postmenopausal	
<b>PREVIOUS TREATMENT:</b>	
<input type="checkbox"/> Colposcopy <input type="checkbox"/> Laser <input type="checkbox"/> Cryotherapy <input type="checkbox"/> LEEP <input type="checkbox"/> Knife cone <input type="checkbox"/> Irradiation <input type="checkbox"/> Wide local excision	
Date (dd/mmm/yyyy)	
<b>HYSTERECTOMY:</b>	Previous cancer
<input type="checkbox"/> Total <input type="checkbox"/> Subtotal	
<b>PRESENT TREATMENT:</b>	
Hormonal: <input type="checkbox"/> HRT <input type="checkbox"/> OCP <input type="checkbox"/> IUCD	
<b>COMMENTS:</b>	
.....	

<b>SPECIMEN PREPARATION:</b>
<input type="checkbox"/> Liquid based cytology <input type="checkbox"/> Conventional cytology
<b>INSTRUMENT(S):</b>
<input type="checkbox"/> Broom <input type="checkbox"/> Spatula <input type="checkbox"/> Cytobrush
<b>SOURCE:</b>
<input type="checkbox"/> Cervix <input type="checkbox"/> Vagina

<b>PROVIDER INFORMATION</b>				
Last name	First name			
CervixCheck/Provider #	Bill to (#)			
Send report to (street address)				
City/Town	Prov	Postal code		
Phone	Fax			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Copy report to (name)</td> </tr> <tr> <td style="padding: 5px;">Address</td> </tr> </table>			Copy report to (name)	Address
Copy report to (name)				
Address				

<b>DESIGNATION:</b>		
<input type="checkbox"/> Physician	<input type="checkbox"/> Nurse practitioner	<input type="checkbox"/> Nurse
<input type="checkbox"/> Physician assistant	<input type="checkbox"/> Clinical assistant	<input type="checkbox"/> 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 #