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

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 # |