

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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Gamma Dynacare Medical Laboratories
830 King Edward St, Ste #100, Winnipeg, MB R2H 0P4
Ph: (204) 944-0757 Fax: (204) 957-1221 | <input type="checkbox"/> Health Sciences Centre Cytology Laboratory
820 Sherbrook St (MS337), Winnipeg, MB R3A 1R9
Ph: (204) 787-1352 Fax: (204) 787-1790 | <input type="checkbox"/> 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 |
| <input type="checkbox"/> St. Boniface Hospital Cytology Laboratory
409 Taché, Winnipeg, MB R2H 2A6
Ph: (204) 237-2504 Fax: (204) 235-3423 | <input type="checkbox"/> 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 #	
		<input type="checkbox"/> F <input type="checkbox"/> M	
Date of birth (dd/mmm/yyyy)		Gender	3 rd 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)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Postpartum _____ (# weeks) |
| <input type="checkbox"/> Menopausal | <input type="checkbox"/> Postmenopausal |

PREVIOUS TREATMENT:

- | | | | |
|-------------------------------------|--------------------------------------|--|-------------------------------|
| <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)

HYSTERECTOMY:

- | | |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Total | <input type="checkbox"/> Subtotal |
|--------------------------------|-----------------------------------|

Previous cancer

PRESENT TREATMENT:

- | | | | |
|-----------|------------------------------|------------------------------|-------------------------------|
| Hormonal: | <input type="checkbox"/> HRT | <input type="checkbox"/> OCP | <input type="checkbox"/> 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:

- | | | |
|--|---|----------------------------------|
| <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 #