THIS SPACE FOR LAB USE ONLY: PLACE LIS LABEL HERE



NON-GYNAECOLOGICAL CYTOLOGY LABORATORY REQUISITION DEPARTMENT OF PATHOLOGY THIS SPACE FOR LAB USE ONLY: PLACE AP LABEL HERE

NAME OF PHYSICIAN	LOCATIONWARD:
ORDERING TEST:(LAST) (FIRST)	
	PATIENT NAME: (LAST) (FIRST)
Copy of report to:	
Address Fax/Phone	DATE OF BIRTH: SEX: DM DF (DD/MM/YYYY)
REFERRING INSTITUTION NAME AND ADDRESS	(DD/WWW1111)
OR CODE (FOR EXTERNAL LOCATIONS):	FACILITY HEALTH RECORDS NO:
CONTACT	PERSONAL HEALTH ID NO(PHIN):
TELEPHONE PAGER	PATIENT PHONE NUMBER(PROV. OR INST.)
PHYSICIAN CRITICAL RESULTS PHONE #:	
	PHYSICIAN (PRINT): (LAST) (FIRST)
PHYSICIAN'S SIGNATURE	(LAST) (FIRST)  COLLECTION DATE and TIME:
PLEASE COMPLETE THE INFORMATION ABOVE, PRINT CLEARLY  ***Specimens may not be examined without the appropriate Demographics and Clinical information***	
*SPECIMENS MUST BE IDENTIFIED WITH PATIENT NAME, PHIN, AND SPECIMEN SITE.  INVESTIGATION REQUIRED:   TUMOR CELLS   OTHER (specify)	
TYPE OF SPECIMEN: (with exact location)	
□BAL □ right □ left	□Sputum
□Bronchial wash □ right □ left	□Pleural
□Bronchial brush □ right □ left	□Peritoneal □fluid □washing
$\Box$ Urine $\Box$ voided $\Box$ catheterized	□Pericardial
□Breast □ right □ left	□CSF
□FNA (specify site)	
□Other (specify)	
CLINICAL DATA:	
Any previous tumors (malignant or benign)	
Please list all relevant clinical information.	





## Appendix 1 DSM Non-Gynaecological Cytology Requisition Information Sheet

**Note**: - Duplicate or triplicate copies of requisition no longer required.

- Use this requisition for all Cytology specimens **except** PAP smears

- Print Clearly

- 1. Complete the following **required** physician demographics:
  - Name of physician ordering test: Last Name, First name
  - If other physicians require a copy of the report include
    - O Physician's Name: Last name, First name
    - o Physician's Address
    - O Physician's fax number/ phone number
  - If specimen is being referred in from an external location include:
    - O Name of referring institution; and
    - Address of referring institution.
  - If physician requests to be contacted by the pathologist:
    - Contact: Last name, First name;
    - Telephone number; and
    - Pager number.
  - Physician's **signature** (or designate- for non invasive procedures)
  - Indicate the appropriate location for the final report
- 1. Complete all of the following **required** patient demographics:
  - Patient Name: Last name, First name;
  - Date of birth: dd/mm/yyyy;
  - · Check the appropriate box indicating gender;
  - Facility Medical Records Number (MRN);
  - PHIN (or equivalent);
  - Out-of-Province patients must indicate the PHIN number including the issuing province;
  - Print physician's name: Last name, First name; and
  - Specimen collection date and time
- 2. <u>One specimen per requisition.</u>
- 3. Indicate the type of fixative which specimens are submitted in (if applicable).
- 4. Indicate the type of specimen(s) submitted.
- 5. Indicate Investigation Required. I.e. Tumor cells, virals, PCP, etc.
- 6. Document the type of operation or procedure performed.
- 7. Document all relevant clinical data including any previous pathology/cytology.

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