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NON-GYNAECOLOGICAL CYTOLOGY LABORATORY REQUISITION DEPARTMENT OF PATHOLOGY

NAME OF PHYSICIAN
ORDERING TEST:
(LAST) (FIRST)

Copy of report to:
Address
Fax/Phone

REFERRING INSTITUTION NAME AND ADDRESS
OR CODE (FOR EXTERNAL LOCATIONS):

CONTACT

TELEPHONE PAGER

PHYSICIAN CRITICAL RESULTS PHONE NUMBER.....

PHYSICIAN'S SIGNATURE

LOCATION/WARD:

PATIENT NAME:
(LAST) (FIRST)

DATE OF BIRTH: GENDER: M F
DD/MM/YYYY

FACILITY HEALTH RECORD NO.:

PERSONAL HEALTH ID NO. (PHIN):
(PROV. OR INST.)

PATIENT PHONE NUMBER.....

PHYSICIAN (PRINT):
(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
- Urine Voided Catheterized Pericardial Fluid
- 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
 - Physician's Name: Last name, First name
 - Physician's Address
 - Physician's fax number/ phone number
 - If specimen is being referred in from an external location include:
 - 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 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. One specimen per requisition.

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.