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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: ..... DD/MM/YYYY GENDER: ☐ M ☐ F

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
☐ Bronchial wash ☐ Right ☐ Left
☐ Bronchial brush ☐ Right ☐ Left
☐ Urine ☐ Voided ☐ Catheterized
☐ Breast ☐ Right ☐ Left
☐ FNA (specify site) _____
☐ Other (specify) _____

☐ Sputum
☐ Pleural
☐ Peritoneal ☐ Fluid ☐ Washing
☐ Pericardial Fluid
☐ CSF

**CLINICAL DATA:**

Any previous tumors (malignant or benign) _____

Please list all relevant clinical information.

☐ Bethesda Hosp Lab, 316 Henry St, Steinbach, MB, R5G 0P9
☐ DeSalaberry DHC Lab, 454 Prefontaine Ave, St Pierre, MB, R0A 1V0
☐ Ste. Anne Hosp Lab, 52 St Gerard Street, Ste Anne, MB, R5H 1C4
☐ Vita & DHC Lab, 217-1st Avenue West, Vita, MB R0A 2K0

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