

PIN#: \_\_\_\_\_  
 NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
 SEX: \_\_\_\_\_ D.O.B.(yyyy/mm/dd): \_\_\_\_\_  
 OHC#: \_\_\_\_\_ Version Code: \_\_\_\_\_

**CYTOPATHOLOGY REQUISITION**

Department of Pathology: (519) 685-8500 Ext. 32956

Source:  SJHC  SSC  UC  WC  Other: \_\_\_\_\_  
 Submitting Physician: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_  
PRINTED NAME YYYYY/MM/DD

**NON-GYNAECOLOGICAL**

Clinical Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Urinary:**

Urine:  Voided  Catheter  Cysto / Bladder Washing  
 Ureter / Renal Pelvis:  Right  Left

**Fluids:**

Effusion  Washing  
 Pleural  Peritoneal  Pericardial  CSF  Ocular  Other: \_\_\_\_\_  
 Site: \_\_\_\_\_

**Respiratory:**

Sputum  Post Bronch Sputum  
 Bronchial:  Wash  Brush Site: \_\_\_\_\_

**Gastrointestinal/Hepatobiliary:**

Brush  Wash  
 Site: \_\_\_\_\_

**Aspiration Biopsy:**  Right  Left

<input type="checkbox"/> Bone	<input type="checkbox"/> Liver	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Breast	<input type="checkbox"/> Lung	<input type="checkbox"/> Salivary Gland	<input type="checkbox"/> Other FNA: _____
<input type="checkbox"/> Kidney	<input type="checkbox"/> Lymph Node	<input type="checkbox"/> Soft Tissue	

**Other (specify):** \_\_\_\_\_

**GYNAECOLOGICAL**

**Specimen Type:**  Liquid Based  Conventional  
 Combined C/E  Cervical  Endocervical  Vaginal

**Date of last menstrual period:** \_\_\_\_\_

<input type="checkbox"/> Contraceptive Therapy	<input type="checkbox"/> IUD	<input type="checkbox"/> Estrogen Therapy
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Post Menopausal	<input type="checkbox"/> Irradiation
<input type="checkbox"/> Post Partum		

Previous Abnormal Smear: \_\_\_\_\_  
 \_\_\_\_\_

Previous Colposcopy: \_\_\_\_\_  
 \_\_\_\_\_