CYTOLOGY & HPV TESTING REQUISITION

CLEAR FORM

LifeLabs

Requesting Clinician/Practitioner

Name

Address

Clinician/Practitioner Billing Number

Laboratory Use Only

Clinician/Practitioner Phone Number

Patient Chart Number

Health Card Number (HCN) | Version | Sex ☐ M ☑ F | Date of Birth YYYY MM DD

Copy to Clinician(s)/Practitioner(s) *(fill in all fields):*

Name Billing #

Address

Name Billing #

Address

Province | Other Province's Registration Number | Patient Phone Number

Patient Last Name *(as per Health Card)*

Patient First Name & Middle Names *(as per Health Card)*

Patient Address *(including postal code)*

GYNECOLOGIC CYTOLOGY (PAP TEST)

Clinical Indication *(check one)*:

- ☐ Pap screening according to Ontario Cervical Screening Guidelines
- ☐ Pap for follow-up of a previous abnormal test result *(specify below)*
- ☐ Pap during colposcopic exam
- ☐ Patient Pay *(none of the above; the patient has been informed that payment to LifeLabs is required.)*

Specimen Collection Date: YYYY MM DD

Last Menstrual Period *(first day):* YYYY MM DD

Site: ☐ Cervical/Endocervical ☐ Vaginal ☐ Other *(specify below)*

Cervix: ☐ Normal ☐ Abnormal *(specify below in Clinical History/Remarks)*

Clinical Status:

- ☐ Pregnancy
- ☐ Post Menopausal
- ☐ IUD
- ☐ Irradiation
- ☐ Post Partum
- ☐ Post Menopausal Bleeding
- ☐ Hormone Replacement Therapy
- ☐ Other *(specify below in Clinical History/Remarks)*

Hysterectomy: ☐ Sub-total (cervix present) ☐ Total (no cervix)

NON-GYNECOLOGIC CYTOLOGY

☐ OHIP/Insured ☐ Third Party/Uninsured ☐ WSIB

Specimen Collection Date: YYYY MM DD

# of Specimens Submitted | # of Slides Submitted

Urine: ☐ Voided ☐ Catheterized ☐ Bladder Wash

Respiratory: ☐ Sputum ☐ Bronchial Brush ☐ Bronchial Wash

Site/Side *(if applicable):*

Fluids: ☐ Pleural ☐ Peritoneal ☐ CSF ☐ Other *(specify)*

Site/Side *(if applicable):*

Thyroid: ☐ Left ☐ Right ☐ Cyst ☐ Nodule ☐ Single ☐ Multiple

Breast: ☐ Left ☐ Right ☐ Cyst fluid ☐ FNA of Mass ☐ Nipple Discharge

Fine Needle Aspiration Biopsy: ☐ Left ☐ Right

- ☐ Kidney
- ☐ Liver
- ☐ Other *(specify):*
- ☐ Salivary Gland
- ☐ Lymph Node *(specify)*
- ☐ Lung
- ☐ Pancreas

Other Site *(specify)*

Clinical History/Remarks:

Inadequate clinical information may hinder diagnosis. For accurate and timely cytologic diagnosis, provide all information required.

HPV TESTING

HPV testing can be ordered, at the patient's request, on the same sample that is submitted for a Pap test

HPV testing can be useful in the management of women over the age of 30. HPV testing under the age of 30 is not recommended.

HPV testing is not currently funded by the MOH. An invoice will be sent to the patient with instructions on how to make the payment. The patient is responsible to pay the current price as of date of collection. Visit LifeLabs.com/test/hpv-testing/ for pricing

- ☐ Reflex HPV test to be done only if ASCUS or LSIL
- ☐ HPV and Cytology co-testing on the same SurePath sample
- ☐ HPV DNA test only (No cytology to be performed on this SurePath sample)

Specimen Collection Date: YYYY MM DD

Physician signature:

By signing I acknowledge that I will be invoiced for, and required to pay the current price to LifeLabs for the HPV test.

Patient signature:

PRINT FORM

Cyto-HPV Req