



Affix Cytology
Laboratory Label
Here



HCN: _____
 Province/Territory: _____ Expiry: YYYY / MON / DD
 Name: _____ First Middle Surname
 Date of Birth: YYYY / MON / DD Sex: M F UN
 Mailing Address: _____
 City: _____ Prov/Terr: _____ Postal Code: _____
 Telephone: (Indicate Preferred) Home (____) - ____ - ____
 Cell (____) - ____ - ____ Work (____) - ____ - ____

PAP Smear Requisition

Ordering Provider's Name: _____ Clinic Name: _____ Mailing Address: _____ City: _____ Prov/Terr: _____ Postal Code: _____ Phone: (____) - ____ - ____ Fax: (____) - ____ - ____ Ordering Provider's Meditech Mnemonic: _____ Signature: _____ Date: <u>YYYY</u> / <u>MON</u> / <u>DD</u>	Clinic Stamp: (include fax, provider and mnemonics) EMR Clinic Mnemonic: _____ COPY TO PROVIDER _____
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Date Specimen Taken: <u>YYYY</u> / <u>MON</u> / <u>DD</u>	Source of Specimen: Cervical/Endocervical Vaginal
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Clinical History: Post-Menopausal? Yes No (If No, LMP mandatory) Last Menstrual Period: <u>YYYY</u> / <u>MON</u> / <u>DD</u> Hysterectomy? Yes No Abnormal Bleeding? Yes No Previous Abnormal Pap/Colposcopy? Yes No Specify _____: HPV Vaccination? Yes No Previous Pap Smear? Yes No If yes, date: <u>YYYY</u> / <u>MON</u> / <u>DD</u>	Medications: BCP HRT Chemotherapy/Radiation Depo-Provera IUD Other Significant History/Colposcopic Findings:
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Laboratory Use Only

Lab Accession Number: _____	Date Specimen Received: <u>YYYY</u> / <u>MON</u> / <u>DD</u>
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Specimen Adequacy: Satisfactory for evaluation Unsatisfactory TZ Present No brush present TZ Absent Rejected	Adequacy Qualifier: Blood Scanty Other Bacteria Improper Labelling Inflammation Leaked Vial Thick Areas
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Technologist Result: Negative (NILM) Shift in Flora ASCUS AGC-NOS Inflammation Actinomyces ASC-H AGC-FN Trichomonas Herpes LSIL AEC Yeast/Fungal Rad/Chemo HSIL AEM C CMV Other SCC AIS Endometrial cells > 45 years Adenoca Other Malignancy	Pathologist Result: ASCUS AGC-NOS ASC-H AGC-FN LSIL AEC HSIL AEM C SCC AIS Other Malignancy
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Recommendations: Routine Screening Repeat 3 months Repeat 6 months Reflex HPV Colposcopy Biopsy ECC EM Sampling
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Technologist/Pathologist Signature: _____ Date: <u>YYYY</u> / <u>MON</u> / <u>DD</u>
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