Gemrook Laboratories – Cytology Requisition

Billing Information	**Patient Information**
Payer Name:	Last Name:
Payer Email:	First Name:
Payer Phone:	DOB (DD/MM/YY):
Payer Address:	Phone:
Requesting Physician:	Email:
Physician Email:	Gender (Male/Female):
Specimen Information	
Specimen ID:	Collection Date (DD/MM/YYY):

TESTING REQUIRED - Cytology

GYNAECOLOGIC CYTOLOGY	**NON-GYNAECOLOGIC CYTOLOGY**
Date of LMP (First Day) YY/MM/DD: _____	Number of Specimens Submitted _____ Number of Slides Submitted _____
Site: □ Cervical □ Combined □ Endocervical □ Vaginal	**Urine:** □ Voided □ Catheterized
Collection Method: □ Liquid Base □ Conventional/Slide	**Thyroid FNA:** □ Left □ Right □ Cyst □ Nodule □ Single □ Multi
Collection Instrument: □ Brush □ Broom □ Spatula	**Body Fluids:** □ Pleural □ Peritoneal **Sputum:** □
Cervix: □ Normal □ Suspicious	**Synovial Fluid:** □ Left □ Right Site: _____
Clinical Status: □ Pregnancy (#wks) □ Post Partum (#wks) □ Post Menopausal □ Post Menopausal Bleeding □ HRT □ BCP □ IUD	**Breast:** □ Left □ Right □ Cyst □ Nodule □ Nipple Discharge **Other Site (Specify)** _____ **Clinical History/Remarks:**
Hysterectomy: □ Total – No Cervix □ Partial – Cervix Present	**Laboratory Use Only** **Fixative Added** □ Yes □ No
Patient History: Is Patient Vaccinated for HPV? □ Yes □ No □ Previous Abnormal Cytology Result/Date _____ □ Biopsy Result/Date _____	**Description:** □ Thick □ Scanty □ Bloody □ Watery □ Clear □ Turbid □ Flocculent □ Color _____ □ Volume_____ ml
Clinical information is important in the interpretation of all Cytology tests. Please provide all relevant clinical information. Clinician Signature: Date:	

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