Providence HEALTH CARE

☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

Apply Patient Label

DEPARTMENT OF PATHOLOGY
CYTOPATHOLOGY REQUISITION

Date of collection: _____

Time: _____

Bill to: ☐ MSP ☐ WCB ☐ RCMP ☐ Self pay ☐ Other

PLEASE CHECK ONE:

- ☐ Bronchial Aspiration
- ☐ Bronchial Brushing
- ☐ Sputum
- ☐ Pleural Fluid
- ☐ Peritoneal Fluid
- ☐ Fine Needle Aspiration
- ☐ Other: (Specify) _____
- ☐ Cerebrospinal Fluid
  - ☐ CJD risk ☐ High ☐ Low
- ☐ Pelvic Washing
- ☐ GI Brushing: (Specify) _____
- ☐ Urine, Catheterized
- ☐ Urine, Voided

Total # OF SPECIMENS SUBMITTED ☐

EXACT SOURCE OF SPECIMEN
(This must match specimen container)

A	
B	

CLINICAL SUMMARY:

RADIOLOGIC IMPRESSION :

Past history/prior malignancy: _____

Previous operation/treatment: _____ Where: _____

Special requests, remarks: _____

_____

Ordering Physician: _____ MSP #: _____

Surgeon or Radiologist: _____ MSP #: _____

Copies of reports to Dr: _____ MSP #: _____

Dr: _____ MSP #: _____

Dr: _____ MSP #: _____

Pathology notes: _____

_____

_____

Requisition must be completed legibly otherwise specimen processing or reporting of results may be delayed.