



LABORATORY REQUEST CYTOLOGY

This form when completed constitutes a referral to VIHA laboratory physicians.

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">ORDERING PHYSICIAN</td> <td colspan="2">Last name, First name</td> </tr> <tr> <td>MSP PRACTITIONER #</td> <td colspan="2"></td> </tr> <tr> <td rowspan="3">Copy of results to:</td> <td>_____</td> <td>MSP# _____</td> </tr> <tr> <td>_____</td> <td>MSP# _____</td> </tr> <tr> <td>_____</td> <td>MSP# _____</td> </tr> </table>	ORDERING PHYSICIAN	Last name, First name		MSP PRACTITIONER #			Copy of results to:	_____	MSP# _____	_____	MSP# _____	_____	MSP# _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center;">Patient Demographic Information</th> </tr> <tr> <td style="width: 50%;">Name</td> <td></td> </tr> <tr> <td>MRN</td> <td></td> </tr> <tr> <td>Encounter</td> <td></td> </tr> <tr> <td>Birthdate (dd/mmm/yyyy)</td> <td style="text-align: center;">GENDER</td> </tr> <tr> <td>PHN</td> <td></td> </tr> <tr> <td>Location / Address</td> <td></td> </tr> <tr> <td colspan="2" style="text-align: center;">PHYSICIAN SIGNATURE:</td> </tr> </table>	Patient Demographic Information		Name		MRN		Encounter		Birthdate (dd/mmm/yyyy)	GENDER	PHN		Location / Address		PHYSICIAN SIGNATURE:	
ORDERING PHYSICIAN	Last name, First name																													
MSP PRACTITIONER #																														
Copy of results to:	_____	MSP# _____																												
	_____	MSP# _____																												
	_____	MSP# _____																												
Patient Demographic Information																														
Name																														
MRN																														
Encounter																														
Birthdate (dd/mmm/yyyy)	GENDER																													
PHN																														
Location / Address																														
PHYSICIAN SIGNATURE:																														

Relevant History and Clinical Diagnosis:

Date Collected: dd/mmm/yyyy

Time Collected:

Collected By: (print)

Exact Site and Type of Sample:

** Fix Cytology Samples in **CytoLyt**[®]

	Sample	Laterality/Location	Initials/Signature
1	<input type="checkbox"/> Sputum <input type="checkbox"/> FNA <input type="checkbox"/> Washing <input type="checkbox"/> Fluid <input type="checkbox"/> Brush <input type="checkbox"/> Urine – voided <input type="checkbox"/> Urine – catheterized <input type="checkbox"/> Lavage <input type="checkbox"/> Other - Specify _____		
2	<input type="checkbox"/> Sputum <input type="checkbox"/> FNA <input type="checkbox"/> Washing <input type="checkbox"/> Fluid <input type="checkbox"/> Brush <input type="checkbox"/> Urine – voided <input type="checkbox"/> Lavage <input type="checkbox"/> Urine – catheterized <input type="checkbox"/> Other - Specify _____		
3	<input type="checkbox"/> Sputum <input type="checkbox"/> FNA <input type="checkbox"/> Washing <input type="checkbox"/> Fluid <input type="checkbox"/> Brush <input type="checkbox"/> Urine – voided <input type="checkbox"/> Lavage <input type="checkbox"/> Urine – catheterized <input type="checkbox"/> Other - Specify _____		
4	<input type="checkbox"/> Sputum <input type="checkbox"/> FNA <input type="checkbox"/> Washing <input type="checkbox"/> Fluid <input type="checkbox"/> Brush <input type="checkbox"/> Urine – voided <input type="checkbox"/> Lavage <input type="checkbox"/> Urine – catheterized <input type="checkbox"/> Other - Specify _____		

Total number of samples submitted for Cytology:

If more than 4 samples, please use an additional requisition and submit all samples and requisitions together.