

Cervical Cancer Screening Lab Requisition Form

Note: Samples must be properly labeled with the patient's surname and date of birth or sample will be rejected.
Requisition sections in red are required information, please complete form appropriately or sample may be rejected.
Reports are sent to Follow-up Practitioners. If other providers require a copy, please complete the 'Copy to' field.

Patient PHN	Patient DOB (dd/mmm/yyyy)	Follow-up Practitioner/Clinic MSC, Name, Address	
Patient Last Name	Patient First Name & Initials		
Sex Female Transmale Other:		Sample Provider MSC & Name	locum RN ND
Sample Date (dd/mmm/yyyy)	LMP Date (dd/mmm/yyyy)		
		Copy to MSC & Name	Copy to MSC & Name
SAMPLE SITE: Cervix/Endocervix Vaginal vault/Wall	REASON FOR TEST: Asymptomatic screening Clinical abnormality Abnormal bleeding Suspicious lesion Follow-up for ASCUS/LSIL Treatment follow-up	HISTORY OF HISTOLOGICALLY PROVEN CERVICAL ABNORMALITY: within 5 years Invasive cervical carcinoma CIN2, CIN3, HSIL (by histology) more than 5 years ago Invasive cervical carcinoma CIN2, CIN3, HSIL (by histology) AIS	
COLLECTION METHOD: Spatula Brush Broom	CLINICAL INFORMATION: Immunocompromised Pregnant Post partum Post menopausal IUD Oral contraceptive pill Estrogen Progesterone HPV immunization Pelvic radiation		
Total hysterectomy (cervix removed) Date: Pathology number: No cervical abnormality CIN2, CIN3, HSIL (by histology) AIS Invasive cervical carcinoma Endometrial carcinoma			
CLINICAL COMMENTS:			
DELIVER SAMPLES TO: Cervical Cancer Screening Laboratory 655 West 12 th Avenue Vancouver, BC V5Z 4R4	CONTACT: (T): 1-877-747-2522 (1-877-PHSA-LAB) (F): 604-707-2809 Supplies (F): 604-707-2606		LAB USE ONLY: