PROVINCIAL Health Services AUTHORITY

BC Cancer Agency
Vancouver Cancer Centre

600 West 10th Avenue
Vancouver, BC, Canada V5Z 4E6
Tel.: 604-877-6000 x 2101
Fax: 604-873-5384

DIAGNOSTIC CYTOLOGY REQUISITION

NOTE: **Each specimen/part type must have a separate fully completed requisition.**
All specimens, requisitions and slides must be labelled.
Lack of/or unclear information will result in a delay or failure of processing.
PHSA Labs are not responsible for unlabelled specimens.

Specimen Collection Date

STAT ☐

Specimen Fixed: ☐ **No** ☐ **Yes**

Type of Fixative:

Number Of Slide(s) **FIXED**

Number Of Slide(s) **UNFIXED**

SPECIMEN TYPE:

Respiratory

- ☐ **SPUTUM** — **Specific Lobe**
- ☐ **BRONCHIAL WASH** ☐ **L** ☐ **R** _____
- ☐ **BRONCHIAL BRUSH** ☐ **L** ☐ **R** _____
- ☐ **BRONCHOALVEOLAR LAVAGE** ☐ **L** ☐ **R** _____
- ☐ **EBUS Lymph Node** **SPECIFY SITE:** _____

Urinary

- ☐ **URINE - VOIDED** ☐ **ILEAL CONDUIT**
- ☐ **URINE - CATHETERIZED** ☐ **URETER** ☐ **L** ☐ **R**
- ☐ **URINE - CYSTOSCOPY** ☐ **RENAL PELVIS** ☐ **L** ☐ **R**
- ☐ **OTHER** **SPECIFY SITE:** _____

Fluids

- ☐ **CEREBROSPINAL FLUID**
- ☐ **PLEURAL FLUID** ☐ **L** ☐ **R**
- ☐ **PERITONEAL** ☐ **FLUID** ☐ **WASH**
- ☐ **PERICARDIAL FLUID**
- ☐ **JOINT FLUID** ☐ **L** ☐ **R** **SPECIFY SITE:** _____

Fine Needle Aspirate

- ☐ **BREAST** ☐ **L** ☐ **R** **SPECIFY SITE:** _____
- ☐ **THYROID** ☐ **L** ☐ **R** ☐ **Isthmus**
- ☐ **OTHER** ☐ **L** ☐ **R** **SPECIFY SITE:** _____

Other

- ☐ **ANAL - RECTAL**
- ☐ **NIPPLE DISCHARGE** ☐ **L** ☐ **R**
- ☐ **OTHER** **SPECIFY SITE:** _____

Print Form | Reset Form

PATIENT DEMOGRAPHICS

Enter data manually, addressograph, or affix label

NAME (LAST)

NAME (FIRST)

BIRTH DATE (DD/MM/YYYY)

CARE CARD NUMBER (PHN)

BCCA NUMBER

SEX ☐ M ☐ F ☐ OTHER Specify

Send Reports To: **DOCTOR MSC#** _____

Doctors Name and Address: Office, Clinic or Hospital

Send Copy To:

MSC# _____ Name: _____

MSC# _____ Name: _____

MSC# _____ Name: _____

Previous Malignancy: ☐ YES ☐ NO

DATE: _____ TYPE: _____

CLINICAL DATA:

Radiation Therapy: ☐ YES DATE: _____

Chemotherapy: ☐ YES DATE: _____

CLINICAL INFORMATION:

Adequate clinical information is essential for accurate cytological interpretation.

LAB USE ONLY:

PAP ☐ MGG ☐

OTHER ☐ CB ☐

THIN ☐ TOTAL ☐

REQUISITION LABEL