PROVINCIAL Health Services AUTHORITY
BC CANCER Provincial Health Services Authority

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 _____

Number Of Slide(s) **FIXED** _____

RUSH ☐

Specimen Fixed: ☐ **No** ☐ **Yes**

Type of Fixative: _____

Number Of Slide(s) **UNFIXED** _____

SPECIMEN TYPE:

Respiratory

		Specific Lobe
☐ **SPUTUM**		
☐ **BRONCHIAL WASH**	☐ **L** ☐ **R**	_____
☐ **BRONCHIAL BRUSH**	☐ **L** ☐ **R**	_____
☐ **BRONCHOALVEOLAR LAVAGE**	☐ **L** ☐ **R**	_____
☐ **EBUS Lymph Node**	**SPECIFY SITE:**	_____
☐ **LUNG FNA**	**SPECIFY LOBE:**	_____

Urinary

☐ **URINE - VOIDED**
☐ **URINE - CATHETERIZED**
☐ **URINE - CYSTOSCOPY**
☐ **ILEAL CONDUIT**
☐ **URETER** ☐ **L** ☐ **R**
☐ **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:** _____

MISCELLANEOUS

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

Print Form

PATIENT DEMOGRAPHICS

Enter data manually, addressograph, or affix label

NAME (LAST)

NAME (FIRST)

BIRTH DATE (DD/MM/YYYY)

CARE CARD NUMBER (PHN)

MRN 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: DATE: _____

Chemotherapy: DATE: _____

CLINICAL INFORMATION:
Adequate clinical information is essential for accurate cytological interpretation.

LAB USE ONLY:

PAP ☐ MGG ☐
OTHER ☐ CB ☐
THIN ☐ TOTAL ☐

REQUISITION LABEL