PROVINCIAL Health Services AUTHORITY
BC CANCER VANCOUVER
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\Time

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**
☐ **OTHER** **SPECIFY SITE:**

☐ **ILEAL CONDUIT**
☐ **URETER** ☐L ☐R
☐ **RENAL PELVIS** ☐L ☐R

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:**

PATIENT DEMOGRAPHICS

Enter data manually, addressograph, or affix label

PATIENT NAME (LAST)

PATIENT NAME (FIRST)

DATE OF BIRTH (DD/MM/YYYY)

PERSONAL HEALTH NUMBER

MEDICAL RECORD NUMBER

SEX ☐M ☐F ☐U ☐X

Send Report To:
Medical Service Plan (MSP) Number

Doctors First & Last Name, Address, Phone Number:
Office, Clinic or Hospital

Send Copy To:

MSP# _____ Name: _____

MSP# _____ Name: _____

MSP# _____ 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 ☐ CELL BLOCK ☐
THIN ☐ TOTAL ☐

REQUISITION LABEL

PRINT FORM **CLEAR FORM**

DATE SIGNED:
REQUESTING PHYSICIAN SIGNATURE:

V19. May2025