CST CERNER DIAGNOSTIC CYTOLOGY REQUISITION

NOTE: Submit one requisition per specimen.
All specimens, requisitions and slides must be labelled.
Missing or illegible information may result in a delay of processing.

Collection Date:	**Time:**
RUSH	**Specimen Fixed:** NO YES **Type of Fixative:**

Respiratory

			Specify Site
Bronchial Wash	L	R	______
Bronchial Brush	L	R	______
BAL (Bronchoalveolar lavage)	L	R	______
EBUS Lymph Node			______
Lung FNA			______
Sputum			______

Urinary

Urine - Voided		
Urine - Catheterized		
Urine - Cystoscopy		
Ileal Conduit		
Ureter	L	R
Renal Pelvis	L	R
Other: ______		

Fluids

			Specify Site
Joint Fluid	L	R	______
Pleural Fluid	L	R	
Peritoneal Fluid			
Peritoneal Wash			
Pericardial Fluid			
Pelvic Wash			
Cerebrospinal Fluid			

Fine Needle Aspirate

			Specify Site
Thyroid Isthmus	L	R	______
Breast	L	R	______
Pancreas			______
Other: ______			

Miscellaneous

			Specify Site
Nipple Discharge	L	R	______
Bile Duct Brushing			
Anal-Rectal			
Other: ______			

PATIENT DEMOGRAPHICS

Enter data manually, addressograph, or affix label

NAME (Last name, First name Middle names)

BIRTHDATE (DD/MM/YYYY)

SEX: Male Female Other - Specify:______

HEALTH CARD NUMBER (PHN)

MRN NUMBER

ENCOUNTER NUMBER

Bill to: MSP WCB Self-Pay Other

Send Reports to:

Ordering Physician: **MSP#:** ______
Doctor's Name & Address of Office, Clinic or Hospital

Send Copies To :

Physician: ______ MSP#: ______

Physician: ______ MSP#: ______

Physician: ______ MSP#: ______

Clinical Information:

Adequate clinical information is essential for accurate cytological interpretation.

Previous Malignancy:
Type: ______ Date: ______

Previous Treatment:
Type: ______ Date: ______

LAB USE ONLY

PAP	MGG	REQUISITION LABEL
THIN	CB	
Total		