Cervical Cancer Screening Lab
HPV + Pap (Cytology) Laboratory Requisition

PROVINCIAL LABORATORY MEDICINE SERVICES
Provincial Health Services Authority

Note: Samples must be properly labeled with the patient's surname and date of birth or sample will be rejected.
Yellow highlighted fields must be completed. Only 1 vial (or 1 swab) is required except for patients with a double cervix.

Patient PHN	Patient DOB (dd/mmm/yyyy)	Follow-up Practitioner/Clinic (MSP#, Name, Address)
Patient Last Name	Patient First Name & Initials	

Gender (for administrative purposes)
☐ FEMALE ☐ MALE ☐ U (Unknown) ☐ X (Non-binary)

Sample Provider (MSP# & Name) ☐ locum ☐ RN ☐ ND

Sample Date (dd/mmm/yyyy)	LMP Date (dd/mmm/yyyy)	Copy to MSP# & Name	Copy to MSP# & Name

COLLECTION METHOD / SAMPLE SITE:

☐ LBC vial: Cervix/Endocervix
☐ LBC vial: Vaginal Vault/Wall *(collected with spatula/brush)*
☐ Vaginal swab: self-collect
☐ Vaginal swab: provider-collect

REASON FOR TEST:

☐ Primary/Asymptomatic screening
☐ Follow-up after self-collect HPV Other High Risk Positive (cytology)
☐ Follow-up at 12-months after HPV Other High Risk Postive (HPV)
☐ Follow-up after colposcopy discharge (Co-Test)
☐ Clinical abnormality - Abnormal bleeding (unexplained)*
☐ Clinical abnormality - Suspicious lesion*

**A screening test is not appropriate for individuals with signs/symptoms suggestive of cervical cancer. Further investigation is required. A Co-Test (HPV and cytology) will be performed but test results are not required for referral.*

CLINICAL INFORMATION:

☐ IUD
☐ DES exposure in utero
☐ Pelvic radiation
☐ Immunocompromised**

***Please refer to the BC Cancer Cervix Screening Program Overview document*
http://www.bccancer.bc.ca/screening/health-professionals/cervix/resources

CLINICAL COMMENTS:

REASON FOR TEST - COLPOSCOPY USE ONLY

HPV
☐ Follow-up of HPV Other High Risk Positive
☐ Follow-up of HPV 16/18 Positive
☐ Other *(please specify)*:_____

Co-Test
☐ Follow-up of CIN2+ or AIS
☐ DES exposure in utero
☐ Investigation of clinical abnormality *(please specify)*:_____

Cytology only
☐ Follow-up of HPV 16/18 or OHR Positive
☐ Other *(please specify)*: _____

OUT OF PROVINCE cervical abnormality (histologically proven)

Date: _____ Location:_____
☐ CIN2, CIN3 ☐ AIS (Adenocarcinoma in situ)
☐ Invasive cervical carcinoma

Total Hysterectomy (cervix removed)

Date: _____ Pathology number. : _____
☐ Unknown reason ☐ Invasive cervical carcinoma
☐ No cervical abnormality ☐ Endometrial carcinoma
☐ CIN2, CIN3 ☐ Malignant, other:
☐ AIS (Adenocarcinoma in situ) *Please specify:*_____

DELIVER SAMPLES TO:
Cervical Cancer Screening Laboratory
655 West 12th Avenue
Vancouver, BC
V5Z 4R4

CONTACT:
(T): 1-877-747-2522 (1-877-PHSA-LAB)
(F): 604-707-2809

Supplies and electronic requisition:
http://www.bccancer.bc.ca/health-professionals/clinical-resources/laboratory-services/cervical-cancer-screening

LAB USE ONLY: