Intermountain Health

Pathology/Cytology Requisition

iCentra Label

Date Collected: _____/____ /_____

Provider Name/Phone and Location: _____

Other Referring Physicians: _____

Frozen Section: ☐ Intraoperative Consultation: ☐

Call with Results To/OR Room #: _____

Pre-op Diagnosis/Clinical History: (Required for all testing)	Lab Use Only:
Special Instructions/Additional Testing/Priority Testing:	

Flow Cytometry Tests:

☐ Flow Cytometry, Leukemia/Lymphoma Phenotyping:
Indication (Required): ☐ Lymphadenopathy ☐ Abdominal/Pelvic Mass Other Indication (Specify): _____

☐ Flow Cytometry Specimen Hold. Pathologist may add FLOWL if indicated. Source:_____

☐ CD4/CD8, Bronchoalveolar Lavage, by Flow Cytometry: Source (BAL Only):_____

Molecular Tests:

☐ Molecular Priority: Place in formalin and record *Collection Time* and *Time in Formalin* below.

☐ Thyroid Molecular Testing (must collect separate cytology sample): Afirma: ☐ ThyroSeq: ☐

Microbiology Test:

☐ Cultures – Shared Specimen with Microbiology: Submit separate Microbiology order for culture.

Tissue Pathology: Specimen(s) Source/Site: For additional specimens, use additional forms.

A. _____ F. _____

B. _____ G. _____

C. _____ H. _____

D. _____ I. _____

E. _____ J. _____

Collection Time: _____ *Time Placed in Formalin:* _____

Cytology: *Indicate the specific specimen site.*

A. _____ C. _____

B. _____ D. _____

☐ Special Stains for Opportunistic Infection: (Respiratory Samples Only)

Intraoperative Consultation\Frozen Section Diagnosis:

_____

_____

_____

Time Received: _____ Time Reported: _____

Reported To: _____ Pathologist Signature: _____

Signature:_____