Carle

LABORATORY AND PATHOLOGY SERVICES

NON-GYNECOLOGICAL CYTOLOGY REQUEST FORM

Place Sticker Here

Date:_____/_____/_____ Perf. Provider #:_____

Requesting #:_____ MRN:_____

Name:_____

Date of Birth:_____/_____/_____ Age:_____ Sex:_____ Room #:_____

Location:_____

NON-GYNECOLOGICAL SPECIMEN

- ☐ Breast Cyst Fluid — Left / Right
- ☐ Breast Nipple Discharge — Left / Right
- ☐ Bronchial Brush — Left / Right
- ☐ Bronchial Lavage — Left / Right
- ☐ Bronchial Wash — Left / Right
- ☐ Sputum
- ☐ Cerebrospinal Fluid
- ☐ Urine, Voided
- ☐ Urine, Ileal Conduit
- ☐ Urine, Neobladder
- ☐ Urine, Catheterized
- ☐ Bladder Wash
- ☐ Ureteral Wash — Left / Right
- ☐ Renal Pelvic Wash — Left / Right
- ☐ Pleural Fluid — Left / Right
- ☐ Peritoneal Fluid
- ☐ Pericardial Fluid
- ☐ Pelvic Wash
- ☐ Peritoneal Wash
- ☐ Common Bile Duct Brushing
- ☐ Other: _____ _____

_____ _____

_____ _____

Reason for Test or Diagnosis Code(s):_____ _____

Clinical History:

Physician/Provider Verification Signature:

_____

Date:_____ Time:_____

Signature verifies: Specimen was collected, container is labeled with patient name/clinic #/specimen source, and requisition is complete.

Reflex Urovysion Testing on Urine Specimens following Cytology Policy? ☐ Yes ☐ No

History of Malignancy? ☐ Yes ☐ No

History of Immunosupression? ☐ Yes ☐ No

Second Verification Initials, Badge # and Contact Phone #:

_____

Initials verify: Specimen was collected, container is labeled with patient name/clinic #/specimen source, and requisition is complete.

FINE NEEDLE ASPIRATION

Source:_____ _____ Left / Right

Reason for Test or Diagnosis Code(s):_____ _____

Physician/Provider Verification Signature:

Clinical History:

_____

Date:_____ Time:_____

Signature verifies: Specimen was collected, container is labeled with patient name/clinic #/specimen source, and requisition is complete.

Reflex Thyroid Molecular Testing Following Cytology Policy? ☐ Yes ☐ No

History of Malignancy? ☐ Yes ☐ No

History of Immunosupression? ☐ Yes ☐ No

Second Verification Initials, Badge # and Contact Phone #:

_____

Initials verify: Specimen was collected, container is labeled with patient name/clinic #/specimen source, and requisition is complete.

FOR LAB USE ONLY

Tech DX:	QC DX:	Path DX:
Tech Initials:_____	QC Initials:_____	Path Initials:_____