

NON-GYNECOLOGIC CYTOLOGY

Requesting Clinician/Practitioner	Laboratory Us	se Only						
Name:								
Address								
Address:								
Clinician/Practitioner Billing Number:	Clinician/Practitioner Phone Number				Patient Chart Number			
	Health Card N	lumber (HCN)	Ve		Sex □M □F	Date of Birth		
Copy to Clinician(s)/Practitioner(s) (fill in all fields)	Province	Other Province's	Registration	n Number		Patient Phone Number		
Name:	ame:			lana (na na Unakh Card)				
Billing #:	Patient Last Name (as per Health Card)							
Address:	ame & Middle Names (as per Health Card)							
Name:	Patient Address (including postal code)							
Billing #:								
Address:								
NON-GYNEGOLOGIC CYTOLOGY								
☐ OHIP/Insured ☐ Third Party/Uninsured ☐ WSIB	Thyroid:	☐ Left ☐ Cyst	_	☐ Right ☐ Isthmus ☐ Multiple				
Specimen Collection Date:								
# of Specimens Submitted:								
Urine: ☐ Voided ☐ Catheterized ☐ Bladder V	Breast:	☐ Left☐ Cyst fluid	_	☐ Right ☐ FNA of Mass ☐ Nipple Discharge				
Respiratory: □ Sputum □ Bronchial Brush □ Bronc	Lymph Node: Site:	☐ Left ☐ Neck	☐ Right☐ Groin☐ Other: (specify)					
Site/Side (if applicable):								
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Fluids:	Other (specify)	Salivary Gland: Site:	☐ Left☐ Parotid☐	☐ Right ☐ Sub	mandibular	☐ Sublingual		
Site/Side (if applicable):		Site.	— Furotic	— 505	manaibalai	- Submiguel		
Other Site: (specify)		FNA Biopsy:	☐ Left	☐ Righ	t			
		Site:	☐ Kidney	Lung	•	Other (specify):		
			☐ Liver	☐ Pand	creas			
CLINICAL HISTORY/REMARKS								
Inadequate clinical information may hinder diagnosis. For accurate and timely cytologic diagnosis, provide all information required								