GYNECOLOGIC CYTOLOGY AND HPV (NON-OCSP)

This requisition should only be used for patients outside of the Ontario Cervical Screening Program

Requesting Clinician/Practitioner

Name: _____

Address: _____

_____

Clinician/Practitioner Billing Number: _____

Copy to Clinician(s)/Practitioner(s) (*fill in all fields)*

Name: _____

Billing #: _____

Address: _____

Name: _____

Billing #: _____

Address: _____

Laboratory Use Only

Clinician/Practitioner Phone Number			Patient Chart Number
Health Card Number (HCN)	Version	Sex ❑M ❑F	Date of Birth
Province	Other Province's Registration Number		Patient Phone Number

Patient Last Name *(as per Health Card)*

Patient First name & Middle Names *(as per Health Card)*

Patient Address *(including postal code)*

TEST REQUESTED (CHOOSE ONE)

Screening Test

- ❑ **HPV test (includes reflex cytology if HPV-positive)**
- ❑ Cytology **test only**

Colposcopy Test

- ❑ **Co-test (HPV and cytology)**
- ❑ HPV **test only**
- ❑ Cytology **test only**

Specimen Collection Date: _____

Last Menstrual Period (*first day):* _____

Site: ❑ Cervical/Endocervical ❑ Vaginal ❑ Other *(specify below)*

_____

Cervix: ❑ Normal ❑ Abnormal *(specify in Clinical History/Remarks)*

Clinical Status:

- ❑ Pregnancy
- ❑ Post menopausal
- ❑ IUD
- ❑ Post partum
- ❑ Post Menopausal Bleeding
- ❑ Hormone Replacement Therapy
- ❑ Other (Specify in Clinical History/Remarks)

Hysterectomy: ❑ Sub-total (cervix present) ❑ Total (no cervix)

Clinical History/Remarks

Inadequate clinical information may hinder diagnosis. For accurate and timely cytologic diagnosis, provide all information required.

CYTOLOGY & HPV TESTING

Cytology & HPV testing can be ordered, at the patient's request, on the same sample that is submitted for a Pap test.

HPV & Gynecologic Cytology testing is not funded outside *of the Ontario Cervical Screening Program*. An invoice will be sent to the patient with instructions on how to make the payment. The patient is responsible to pay the current price as of date of collection. The price of the HPV test is $95 and cytology is $60.
For more information, visit LifeLabs.com/test/hpv-testing/

I acknowledge that I have informed my patient that this is a private pay test. The patient will receive an invoice for the cost of the testing with instructions to complete payment.

Specimen Collection Date: _____

Physician Signature:

By signing, I acknowledge that a payment to LifeLabs is required for the HPV/Cyto test.

Patient Signature: