

## COLLECTION OF ENDOMETRIAL WASH



### Specimen Labeling:

All specimens will be clearly labeled **BEFORE** being sent to the laboratory for testing to ensure correct identification of the patient and sample.

All specimens/containers must be labeled with:

- The patient's full name (printed in the same format as patient's health card)
- A second identifier such as date of birth or health card number
- It is recommended that the specimen container also be labeled with specimen source (for non-gynecologic samples)

Specimen/container labeling options are:

- Computer printed label affixed to the side of the specimen container.
- Or clearly printed handwritten information on the label of the specimen container using indelible ink
- Specimen should be collected in ThinPrep container for Cytology, otherwise if tissue is obtained, formalin fixed Histology sample is preferred for optimal result

### Specimen Handling and Transportation:


- Each fluid specimen must be placed into own separate polybag.
- A completed Cytology & HPV Testing Requisition must accompany each specimen.
- Specimens requiring expedited service must be clearly marked as such by the health care provider (HCP) taking the sample. The typical designation is: ASAP.
- For optimal results transport the specimens to the laboratory as soon as possible after collection.

### Cytology Requisition Information:

All specimens must be submitted for testing with a completed Cytology & HPV Testing Requisition. The following information must be provided in a legible format:

- 1.The submitting client information (full name, address and billing number).
  - 2.Complete the copy to - physician information (full name, address and billing number must be provided).
  - 3.Full name of patient (in the same format as patient health card). Health Card Number and Date of birth, Patient address and phone number
  - 4.Date of collection. Site and specimen collection method
- Provide any pertinent clinical information.

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| CYTOLOGY & HPV TESTING REQUISITION   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
|--|---|---|--------------------------|-----------------------|--|--|---------------------------------------|---|--|---|----------------------------|--|--|---|--|--|--|--|--|----------------------------|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|----------------------|--|--|
| <br>Requesting Clinician/Practitioner<br>Name<br>Address<br>Clinician/Practitioner Billing Number   | Laboratory Use Only   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
|  | Clinician/Practitioner Phone Number<br>Patient Chart Number   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Copy to Clinician(s)/Practitioner(s) Name (fill in all fields):<br>Billing #   | Health Card Number (HCN) Version Sex <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth<br>Province Other Province Ion Number Patient Phone Number   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Address<br>Name Billing #<br>Address   | Patient Last Name (as per Health Card)<br>Patient First Name & Middle Names (as per Health Card)<br>Patient Address (including postal code)   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <b>GYNECOLOGIC CYTOLOGY (PAP TEST)</b><br>Clinical Indication (check one):<br><input type="checkbox"/> Pap screening according to Ontario Cervical Screening Guidelines<br><input type="checkbox"/> Pap for follow-up of a previous abnormal test result (specify below)<br><input type="checkbox"/> Pap during colposcopic exam<br><input type="checkbox"/> Patient Pay (none of the above; the patient has been informed that payment to LifeLabs is required.)<br>Specimen Collection Date: YYYY   MM   DD<br>Last Menstrual Period (first day): YYYY   MM   DD<br>Site: <input type="checkbox"/> Cervical/Endocervical <input type="checkbox"/> Vaginal <input type="checkbox"/> Other (specify below)<br>Cervix: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify below in Clinical History/Remarks)<br>Clinical Status:<br><input type="checkbox"/> Pregnancy <input type="checkbox"/> Post Partum<br><input type="checkbox"/> Post Menopausal <input type="checkbox"/> Post Menopausal Bleeding<br><input type="checkbox"/> IUD <input type="checkbox"/> Hormone Replacement Therapy<br><input type="checkbox"/> Irradiation <input type="checkbox"/> Other (specify below in Clinical History/Remarks)<br>Hysterectomy: <input type="checkbox"/> Sub-total (cervix present) <input type="checkbox"/> Total (no cervix) | <b>NON-GYNECOLOGIC CYTOLOGY</b><br><input type="checkbox"/> OHIP/Insured <input type="checkbox"/> Third Party/Uninsured <input type="checkbox"/> WSIB<br>Specimen Collection Date: 4<br><table border="1"> <thead> <tr> <th></th> <th># of Specimens Submitted</th> <th># of Slides Submitted</th> </tr> </thead> <tbody> <tr> <td>Urine: <input type="checkbox"/> Voided <input type="checkbox"/> Catheterized</td> <td></td> <td><input type="checkbox"/> Bladder Wash</td> </tr> <tr> <td>Respiratory: <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial Brush</td> <td></td> <td><input type="checkbox"/> Bronchial Wash</td> </tr> <tr> <td>Site/Side (if applicable):</td> <td></td> <td></td> </tr> <tr> <td>Fluids: <input type="checkbox"/> Pleural <input type="checkbox"/> Peritoneal <input type="checkbox"/> CSF</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other (specify)</td> <td></td> <td></td> </tr> <tr> <td>Site/Side (if applicable):</td> <td></td> <td></td> </tr> <tr> <td>Thyroid: <input type="checkbox"/> Left <input type="checkbox"/> Right</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cyst <input type="checkbox"/> Nodule <input type="checkbox"/> Single <input type="checkbox"/> Multiple</td> <td></td> <td></td> </tr> <tr> <td>Breast: <input type="checkbox"/> Left <input type="checkbox"/> Right</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cyst fluid <input type="checkbox"/> FNA of Mass <input type="checkbox"/> Nipple Discharge</td> <td></td> <td></td> </tr> <tr> <td>Fine Needle Aspiration Biopsy: <input type="checkbox"/> Left <input type="checkbox"/> Right</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Kidney <input type="checkbox"/> Salivary Gland <input type="checkbox"/> Lung</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Liver <input type="checkbox"/> Lymph Node (specify) <input type="checkbox"/> Pancreas</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other (specify):</td> <td></td> <td></td> </tr> <tr> <td>Other Site (specify)</td> <td></td> <td></td> </tr> </tbody> </table> |   | # of Specimens Submitted | # of Slides Submitted | Urine: <input type="checkbox"/> Voided <input type="checkbox"/> Catheterized |  | <input type="checkbox"/> Bladder Wash | Respiratory: <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial Brush |  | <input type="checkbox"/> Bronchial Wash | Site/Side (if applicable): |  |  | Fluids: <input type="checkbox"/> Pleural <input type="checkbox"/> Peritoneal <input type="checkbox"/> CSF |  |  | <input type="checkbox"/> Other (specify) |  |  | Site/Side (if applicable): |  |  | Thyroid: <input type="checkbox"/> Left <input type="checkbox"/> Right |  |  | <input type="checkbox"/> Cyst <input type="checkbox"/> Nodule <input type="checkbox"/> Single <input type="checkbox"/> Multiple |  |  | Breast: <input type="checkbox"/> Left <input type="checkbox"/> Right |  |  | <input type="checkbox"/> Cyst fluid <input type="checkbox"/> FNA of Mass <input type="checkbox"/> Nipple Discharge |  |  | Fine Needle Aspiration Biopsy: <input type="checkbox"/> Left <input type="checkbox"/> Right |  |  | <input type="checkbox"/> Kidney <input type="checkbox"/> Salivary Gland <input type="checkbox"/> Lung |  |  | <input type="checkbox"/> Liver <input type="checkbox"/> Lymph Node (specify) <input type="checkbox"/> Pancreas |  |  | <input type="checkbox"/> Other (specify): |  |  | Other Site (specify) |  |  |
|  | # of Specimens Submitted  | # of Slides Submitted                   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Urine: <input type="checkbox"/> Voided <input type="checkbox"/> Catheterized   |   | <input type="checkbox"/> Bladder Wash   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Respiratory: <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial Brush  |   | <input type="checkbox"/> Bronchial Wash |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Site/Side (if applicable):   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Fluids: <input type="checkbox"/> Pleural <input type="checkbox"/> Peritoneal <input type="checkbox"/> CSF  |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <input type="checkbox"/> Other (specify)   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Site/Side (if applicable):   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Thyroid: <input type="checkbox"/> Left <input type="checkbox"/> Right  |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <input type="checkbox"/> Cyst <input type="checkbox"/> Nodule <input type="checkbox"/> Single <input type="checkbox"/> Multiple  |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Breast: <input type="checkbox"/> Left <input type="checkbox"/> Right   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <input type="checkbox"/> Cyst fluid <input type="checkbox"/> FNA of Mass <input type="checkbox"/> Nipple Discharge   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Fine Needle Aspiration Biopsy: <input type="checkbox"/> Left <input type="checkbox"/> Right  |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <input type="checkbox"/> Kidney <input type="checkbox"/> Salivary Gland <input type="checkbox"/> Lung  |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <input type="checkbox"/> Liver <input type="checkbox"/> Lymph Node (specify) <input type="checkbox"/> Pancreas   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <input type="checkbox"/> Other (specify):  |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Other Site (specify)   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| Clinical History/Remarks:<br>Inadequate clinical information may hinder diagnosis. For accurate and timely cytologic diagnosis, provide all information required.  |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <b>HPV TESTING</b><br>HPV testing can be ordered, at the patient's request, on the same sample that is submitted for a Pap test<br>HPV testing can be useful in the management of women over the age of 30. HPV testing under the age of 30 is not recommended.<br>HPV testing is not currently funded by MOHLTC (but private health insurance plans may cover some of the cost)<br>An invoice of \$90.00 will be sent to the patient with instruction on how to make payment (patient address must be provided)   |   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |
| <input type="checkbox"/> Reflex HPV test to be done only if ASQJ5<br><input type="checkbox"/> HPV and Cytology co-testing on the same Surepath sample<br><input type="checkbox"/> HPV DNA test only (No cytology to be performed on this Surepath sample)<br>Specimen Collection Date:<br>Physician signature:   | By signing I acknowledge that a payment of \$90.00 to LifeLabs is required for the HPV test<br>Patient signature:   |   |                          |                       |  |  |                                       |   |  |   |                            |  |  |   |  |  |  |  |  |                            |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                      |  |  |

### COLLECTION OF ENDOMETRIAL WASH

#### Collection Kit Information:

##### Fine Needle/ Sputum/ Urine Kits:

Kit components are ordered separately:

- 90 mL sterile container with 40 mL of cytology preservative (Cytolyt®- clear, colourless solution).
- Collection instructions are included in the sputum and urine kits
- Polybag
- Cytology requisition (ordered separately)

**Note:** Identical kits are used for Fine Needle Aspirates, Sputum, Urine and Fluid specimens

Preservative MUST NOT be emptied out.



**CAUTION:** The preservative contains methyl alcohol. Do not drink. If ingested, do not induce vomiting; call your doctor or local poison control center immediately. Vapor may be harmful if inhaled; use with adequate ventilation. Flammable; keep away from heat, sparks & open flame. Avoid contact with eyes.

### ENDOMETRIAL WASHINGS

#### Collection Instructions

1. Label the specimen container with the patients' full name and DOB or Health card number, date of collection, sample type and source.
2. ADD specimen to equal parts of cytology preservative.
3. Re-cap the specimen container tightly and shake vigorously for 30 seconds.
4. Submit specimen with completed cytology requisition including ALL pertinent clinical information
5. Keep the preserved specimen at room temperature or refrigerated (2-8°C). It is recommended to return the specimen to the laboratory as soon as possible after collection. Testing of the sample should occur within 8 days from the date of collection for optimal result

**Minimum Specimen Volume:** 10 mL

### Reference

CLSI. GP23-A: *Nongynecological Cytology Specimens: Preexamination, Examination and Postexamination Processes; Approved Guideline- Second Edition*: Wayne, PA CLSI November; 2014.