# CYTOLOGY & HPV TESTING REQUISITION

CLEAR FORM

LifeLabs

Requesting Clinician/Practitioner

Name

Address

Clinician/Practitioner Billing Number

Laboratory Use Only

Clinician/Practitioner Phone Number

Patient Chart Number

Health Card Number (HCN) | Version | Sex ☐ M ☐ F | Date of Birth YYYY MM DD

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

Name Billing #

Address

Name Billing #

Address

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)*

## GYNECOLOGIC CYTOLOGY (PAP TEST)

**Clinical Indication** *(check one)*:

- ☐ Pap screening according to Ontario Cervical Screening Guidelines
- ☐ Pap for follow-up of a previous abnormal test result *(specify below)*
- ☐ Pap during colposcopic exam
- ☐ Patient Pay *(none of the above; the patient has been informed that payment to LifeLabs is required.)*

**Specimen Collection Date:** YYYY MM DD

**Last Menstrual Period** *(first day):* YYYY MM DD

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

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

**Clinical Status:**

- ☐ Pregnancy
- ☐ Post Menopausal
- ☐ IUD
- ☐ Irradiation
- ☐ Post Partum
- ☐ Post Menopausal Bleeding
- ☐ Hormone Replacement Therapy
- ☐ Other *(specify below in Clinical History/Remarks)*

**Hysterectomy:** ☐ Sub-total (cervix present) ☐ Total (no cervix)

## NON-GYNECOLOGIC CYTOLOGY

☐ OHIP/Insured ☐ Third Party/Uninsured ☐ WSIB

**Specimen Collection Date:** YYYY MM DD

# of Specimens Submitted | # of Slides Submitted

**Urine:** ☐ Voided ☐ Catheterized ☐ Bladder Wash

**Respiratory:** ☐ Sputum ☐ Bronchial Brush ☐ Bronchial Wash

Site/Side *(if applicable):*

**Fluids:** ☐ Pleural ☐ Peritoneal ☐ CSF ☐ Other *(specify)*

Site/Side *(if applicable):*

**Thyroid:** ☐ Left ☐ Right ☐ Cyst ☐ Nodule ☐ Single ☐ Multiple

**Breast:** ☐ Left ☐ Right ☐ Cyst fluid ☐ FNA of Mass ☐ Nipple Discharge

**Fine Needle Aspiration Biopsy:** ☐ Left ☐ Right

- ☐ Kidney
- ☐ Liver
- ☐ Other *(specify):*
- ☐ Salivary Gland
- ☐ Lymph Node *(specify)*
- ☐ Lung
- ☐ Pancreas

**Other Site** *(specify)*

**Clinical History/Remarks:**

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

# HPV TESTING

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

**HPV testing is not currently funded by MOHLTC (but private health insurance plans may cover some of the cost)**
**An invoice of $90.00 will be sent to the patient with instruction on how to make payment (patient address must be provided)**

- ☐ Reflex HPV test to be done only if ASCUS
- ☐ HPV and Cytology co-testing on the same Surepath sample
- ☐ HPV DNA test only (No cytology to be performed on this Surepath sample)

Specimen Collection Date: YYYY MM DD

Physician signature:

By signing I acknowledge that a payment of $90.00 to LifeLabs is required for the HPV test

Patient signature:

PRINT FORM

Cyto-HPV Req