Advanced Pathology Laboratory
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CYTOPATHOLOGY REQUISITION

Addressograph or ID Label

Patient Information		
Name: Last First MI	SSN: - -	Sex: ☐ M ☐ F
Medical Record No:	DOB: / /	Phone number: - -
Address:	City:	State: Zip Code:
Insurance Company (Please attach copy of the card):		ID #

Procedure Information, General		
Physician:	Diagnosis:	ICD-9:
Date: / / Time:	Procedure:	
Pertinent History:		
Clinical Information:		

Procedure Information, Specific	
Gynecological	**Non-Gynecological**
☐ Conventional ☐ Thin-prep Number of slides:	☐ FNA Site: Number of slides:
Source: ☐ Vagina ☐ Cervix ☐ Endocervix ☐ Endometrium ☐ Other	☐ Fluid Source: ☐ Sputum ☐ Urine ☐ Synovial ☐ Other:
Clinical status	**Gynecological Biopsy**
LMP: / /	For each specimen please indicate site and side.

Yes	No	
		Birth control pills
		IUD
		Pregnant, weeks:
		Postpartum, weeks
		Post menopausal
		Hormone therapy, specify:
		Hysterectomy
		Chemotherapy
		Radiation therapy
		Previous abnormal PAP, specify:

1-

2-

3-

4-

Special Instructions and Requests	
☐ HPV	☐ Other

Lab Use Only	
Specimen Condition: ☐ Satisfactory ☐ Unsatisfactory, specify:	Number of slides: Date Received: Comments:
Accession #:	Tech initials: