Centre universitaire de santé McGill | McGill University Health Centre

CYTOPATHOLOGY REQUISITION – GYNECOLOGICAL

* Prescriber	*Patient Last Name:
*Last Name & First Name:	*Patient First Name:
*License:	MRN or RAMQ:
*Clinic, office:	Address:
* Address for return of results :	*Date of Birth (yyyy/mm/dd):
*Phone # :	*Gender
*Signature: ..... *Date (yyyy/mm/dd):	*Mandatory Information
Diagnosis or relevant information	***Date and time of collection**
	*20____/_____/_____ *Time: _____
	*Collected by: _____
	☐ URGENT ☐ SCREENING ☐ COLPOSCOPY

SOURCE OF SPECIMEN

☐ Cervix – Endocervix ☐ Vagina ☐ Vulva ☐ Other, specify:

TYPE OF SPECIMEN

☐ Conventionnal cytology/smear ☐ Liquid-based cytology ☐ Cytobrush ☐ Other; specify :

RELEVANT CLINICAL INFORMATION

DATE OF LAST MENSTRUAL PERIOD (YY/MM/DD) :

PREVIOUS ABNORMAL CYTOLOGY	☐ no ☐ yes: *date (YY-MM-DD)*	diagnosis:	
PREVIOUS SURGERY	☐ no ☐ yes: *date (YY-MM-DD)*	specify: ☐ TAH ☐ partial hyst ☐ other; specify:	
CHEMOTHERAPY	☐ no ☐ yes: *date (YY-MM-DD)*	**LASER TREATMENT**	☐ no ☐ yes; date : *date (YY-MM-DD)*
RADIOTHERAPY	☐ no ☐ yes: *date (YY-MM-DD)*	**HORMONE THERAPY / BCP currently**	☐ no ☐ yes
CRYOTHERAPY	☐ no ☐ yes: *date (YY-MM-DD)*	**HPV VACCIN RECEIVED**	☐ no ☐ yes
Pregnant	☐ no ☐ yes	Post-partum	☐ no ☐ yes IUD ☐ no ☐ yes
Menopause	☐ no ☐ yes	Post-menopausal bleeding	☐ no ☐ yes
Condyloma	☐ no ☐ yes	Test HPV-PCR	☐ positive ☐ negative ☐ non available/not done

OTHER CLINICAL INFORMATION

RESERVED FOR LABORATORY CYTODIAGNOSIS

Slides	Block

Type of specimen: _____ Date (yy/mm/dd): _____ Cytology #: _____

Transformation zone present: ☐ Yes ☐ No ☐ Not applicable

☐ Benign ☐ Abnormal ☐ Malignant ☐ Unsatisfactory

Remarks:

_____ M.D.

Cytotechnologist Date (yy/mm/dd) Pathologist

DM -5049 Revised: 2016.05.25