THIS ORDER IS ALSO ACCEPTED WITHIN THE QUEBEC PROVINCIAL HEALTH NETWORK.

100-4800, rue Dobrin
St-Laurent (QC) H4R 2P8
T 800.565.5721
F 514.486.8025

Dynacare Cytology Reference Number

Collection Date: YYYY /MM /DD **Time:** _______

PATIENT:

Last Name First Name DOB: YYYY/MM/DD

Address Apartment

City Postal Code

T (home). T (cell)

#Health insurance number (if required) Gender

CLIENT #: _____________

DOCTOR: ________________________ **License #:** _________

Clinic: ____

Address: ____

T: ______________________ **F:** ____________________

Dr. SIGNATURE: __________________ **Date:** YYYY /MM /DD

Copy to Dr.: ________________________ **F:** ___________

GYNECOLOGIC CYTOLOGY	NON-GYNECOLOGIC CYTOLOGY
Date of last menstrual period (first day) YYYY /MM /DD	_____ Number of Specimens submitted _____ Number of Slides submitted
Complete the Sections (Check)	***Complete the Sections (Check)***
SITE: ☐ Cervical ☐ Combined ☐ Endocervical ☐ Vaginal	***URINE:*** ☐ Voided ☐ Catheterized
COLLECTION METHOD: ☐ Liquid ☐ Conventional/ Slide	***THYROID BIOPSY (FNA):*** ☐ Left ☐ Right ☐ Cyst ☐ Nodule ☐ Simple ☐ Multi
COLLECTION INSTRUMENT: ☐ Brush ☐ Broom ☐ Spatula	***BODY FLUIDS:*** ☐ Pleural ☐ Peritoneal ☐ Sputum
CERVIX: ☐ Normal ☐ Suspicious	***SYNOVIAL FLUIDS :*** ☐ Left ☐ Right Site: _______________
CONTRACEPTION: ☐ Contraceptives ☐ Sterilized	***BREAST:*** ☐ Left ☐ Right ☐ Cyst ☐ Nodule ☐ Nipple Discharge
CLINICAL STATUS: ☐ Pregnancy (#weeks) ____ ☐ Post-Partum (#weeks) ____ ☐ Post Menopausal ☐ Post Menopausal Bleeding ☐ HRT ☐ BCP ☐ IUD	***OTHER SITE:*** *(Specify)*
HYSTERECTOMOMY: ☐ Total –No Cervix ☐ Partial –Cervix present	*Provide all relevant clinical information on cytology requisition.* *The lack of relevant clinical information may affect the final interpretation.*
PATIENT HISTORY: Biopsy transmitted simultaneously? ☐ Yes ☐ No Patient vaccinated for HPV? ☐ Yes ☐ No ☐ Previous abnormal Cytology? Result/ Date : YYYY /MM /DD ☐ Biopsy Result/ Date : YYYY /MM /DD	***CLINICAL HISTORY / REMARKS:***
TEST REQUESTED : ☐ PAP liquid based (**LPAP**) ☐ HPV DNA test (**HPV/DNA**) ☐ PAP liquid based and HPV DNA test (**THINCASC**) ☐ PAP liquid based *and HPV DNA test Reflex if ASCUS present* (**THINPREPREF**)	

Laboratory Use Only:

Fixative added? ☐ Yes ☐ No

DESCRIPTION:

☐ Thick ☐ Scanty ☐ Bloody ☐ Watery ☐ Clear ☐ Turbid ☐ Flocculent

☐ Color ______________________ ☐ Volume ________ mL

For information on our services, access **Dynacare.ca** or our customer care team at 800.565.5721