Dynacare®

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Gynecologic Cytology Requisition (QC)

This order is also accepted within the Quebec provincial health network

Client #: _____ **Specimen collection date** YYYY/MM/DD**:** _____ **Specimen collection time** HH:MM**:** _____

Patient Information

Last name: _____

First Name: _____

Health insurance card #: _____

Date of birth YYYY/MM/DD: _____ Gender: _____

Address: _____

City: _____

Province: _____ Postal code: _____

T (home): _____ **T** (cell): _____

Last menstrual period YYYY/MM/DD: _____

Healthcare Provider Information

Full name: _____ Licence #: _____

Clinic: _____

Address: _____

City: _____

Province: _____ Postal code: _____

T: _____ **F**: _____

Signature: _____ Date: _____

cc. Healthcare Provider

Full name: _____

F: _____

Complete the Sections (X)

Site: *HPV* requires cervical/endocervical specimen

☐ Cervical/Endocervical ☐ Vaginal

Collection method:

☐ Liquid ☐ Conventional/Slide

Collection instrument:

☐ Brush ☐ Broom ☐ Spatula

Cervix:

☐ Normal ☐ Suspicious

Contraception:

☐ Contraceptives ☐ Sterilized

Hysterectomy:

☐ Total – no cervix ☐ Partial – cervix present

Clinical status:

☐ Pregnancy ____ weeks
☐ Post-partum ____ weeks
☐ Post menopausal
☐ Post menopausal bleeding
☐ Immunosuppressed*
☐ Symptomatic – Abnormal bleeding, pain during intercourse, unusual/persistent vaginal discharge
☐ BCP
☐ HRT
☐ IUD

* People for whom immunosuppressed recommendations should be applied to:

- Living with HIV
- Undergone solid organ transplant or transplant allogeneic hematopoietic stem cells
- Systemic lupus erythematosus
- Immunosuppressive treatment for inflammatory bowel disease or rheumatoid arthritis
- Congenital (primary) immunodeficiency

Test(s) requested:

☐ *HPV* with reflex PAP (*HPV* Positive specimens only) - **HPVR**
☐ *HPV* only - **HPV**
☐ Co-test (*HPV* and PAP) - **PAPHPV**
☐ PAP only - **LPAP**
☐ PAP and reflex to *HPV* if ASCUS - **THINPREPREF**
☐ Cytology: PAP smear - **PAPSM**

Patient history:

☐ Biopsy submitted simultaneously?
☐ Patient vaccinated for *HPV*?
☐ Previous abnormal cytology? Result/Date: _____
☐ Biopsy Result/Date: _____

Clinical history/Remarks:

Provide all relevant clinical information on cytology requisition.
The lack of relevant clinical information may affect the final interpretation.

Lab Use Only

Dynacare cytology reference #: _____

Report Language:

☐ French ☐ English