Alpha Laboratories
ADVANCING HEALTHCARE FOR ALL

Requesting Clinician/Practitioner

Name

Address

Clinician/Practitioner Number | CPSO / Registration No.

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results ( ) Ext.

Service Date YYYY MM DD

Health Number | Version | Sex ☐ M ☐ F | Date of Birth YYYY MM DD

Check (✓) one:

☐ **OHIP/ Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

Province | Other Provincial Registration Number | Patient's Telephone Contact Number ( ) Ext.

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

Name Billing #

Address

Name Billing #

Address

Patient's Last Name (*as per Health Card*)

Patient's First and Middle Names (*as per Health Card*)

Patient's Address (*including Postal Code*)

CYTOLOGY AND HPV REQUISITION

GYNAECOLOGIC CYTOLOGY

☐ Pap screening according to Ontario Cervical Screening Guidelines
☐ Pap for follow-up of a previous abnormal test result (*please specify below*)
☐ Pap during colposcopic examination
☐ Patient Pay (*Patient has been informed that payment to Alpha will be required*)

Specimen Collection Date (y/m/d)

Last Menstrual Period (y/m/d)

Site: ☐ Cervical ☐ Vaginal ☐ Endocervical ☐ Vault ☐ Other (*Please Specify*)

Sampling Device: ☐ Cytobrush ☐ Spatula ☐ Broom

Cervix: ☐ Normal ☐ Abnormal (*Please Specify*)

Clinical Status:
☐ Hormonal Therapy (BC pills) ☐ Pregnancy(#wks) _____
☐ IUD in place ☐ Post-Partum(#wks) _____
☐ Hormone Replacement Therapy ☐ Post-Menopausal (years) _____
☐ Discharge ☐ Abnormal bleeding
☐ Amenorrhea
☐ Other (*Please Specify*)

Hysterectomy: ☐ Total (no cervix) ☐ Partial (cervix present)

Clinical History:
☐ Previous Abnormal Cytology *Result/Date:* _____
☐ Colposcopy & Biopsy *Result/Date:* _____
☐ Laser *Date:* _____
☐ Cryotherapy *Date:* _____
☐ Irradiation *Date:* _____
☐ Chemotherapy *Date:* _____
☐ Other (*Please Specify*)

NON-GYNAECOLOGIC CYTOLOGY

Specimen Collection Date (y/m/d)

_____ # of Specimens Submitted _____ # of Slides Submitted

Sputum: ☐

Urine: ☐ Voided ☐ Catheterized

Breast: ☐ Left ☐ Right ☐ Cyst Fluid ☐ Nodule ☐ Nipple discharge

Body Fluids: ☐ Pleural ☐ Peritoneal

Synovial Fluids: ☐ Left ☐ Right ☐ Other Site:

FNA: ☐ Left ☐ Right ☐ Site:

Other: (*Please specify*)

HPV TEST

Specimen Collection Date (y/m/d)

☐ Reflex HPV test (if ASCUS) ☐ HPV & Pap test
☐ HPV test (only) ☐ Patient has been vaccinated for HPV
☐ Patient has been informed that payment to Alpha is required for HPV test

PATIENT ACKNOWLEDGEMENT

By signing below I acknowledge that I am responsible for the payment to Alpha Laboratories for the ☐ HPV test ☐ Patient Pay Pap test

Patient Signature: _____ Date: _____ y/m/d

Clinical History/Remarks (*Please provide all relevant clinical information to ensure accurate and timely cytologic diagnosis.)*

Clinician/Practitioner Signature

Date y/m/d

Laboratory Use Only

Fixative Added: ☐ Yes ☐ No

Gross Description:
☐ Clear ☐ Turbid ☐ Opaque ☐ Watery ☐ Mucinous ☐ Bloody
Volume: _____ ml Colour: _____
Sediment: ☐ Scant ☐ Moderate ☐ Abundant ☐ Nil Visible
Colour: _____
Date Prepared (y/m/d): _____ Time: _____ Initials: _____