ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Nongynecologic Cytopathology Requisition

Important - Form is used for regular and downtime use.
Bold and ***italicized*** fields contain critical data elements that **must be reconciled** for downtime.

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____		Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name		Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone	
Address		City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Cytopathology

☐ Aspirate _____ ☐ Bronchial Wash _____ ☐ Urine voided
☐ BAL _____ ☐ CSF ☐ Peritoneal ☐ Urine catheterized
☐ Bronchial Brush _____ ☐ Sputum ☐ Pleural ☐ Other_____

Specimens
Nature and **exact anatomical site** for each specimen

History **must be provided**

Specimen Appearance *(for lab use only)*

Signature

Tech Comments *(for lab use only)*