CLEAR FORM

ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

GYNECOLOGICAL CYTOPATHOLOGY REQUISITION

REQUIRED INFORMATION

PHYSICIAN TO ACT ON RESULTS: (Apply APL Dr. stamp here)

Physician Last Name /
Full First Name:

5 Digit Client #:

Alpha Suffix Provider #:

PROVINCE | PERSONAL HEALTH NUMBER (PHN) | REGIONAL HEALTH RECORD NUMBER

PATIENT LAST NAME | FULL FIRST NAME | MIDDLE NAME

PATIENT ADDRESS | CITY, PROVINCE | POSTAL CODE

CHART NUMBER | GENDER | DATE OF BIRTH (Y Y Y Y / M M / D D) | PATIENT PHONE NUMBER ( ) -

Is patient under 21? No ☐ Yes ☐

*Routine screening of patients under 21 is **not** recommended. If warranted state clinical reason. Cervical screening should be considered based on TOP Clinical Practice guidelines.*

ADDITIONAL COPIES TO:

1) _____ Last Name _____ Full First Name _____ Office Address/Location

2) _____ Last Name _____ Full First Name _____ Office Address/Location

CURRENT SPECIMEN TAKEN:

Date: __ __ __ __ / __ __ / __ __ (Y Y Y Y / M M / D D)

Time: __ __ : __ __ (H H : M M)

FOR LAB USE ONLY - ACCESSION NUMBER

GYNECOLOGICAL SPECIMEN SITE

☐ Cervix ☐ Vagina ☐ Anal

CLINICAL INFORMATION (please print clearly)

LNMP: __ __ __ __ / __ __ / __ __ (Y Y Y Y / M M / D D) **Cycle:** Every _____ days **Previous Pap Result**: _____ __ __ __ __ / __ __ / __ __ (Y Y Y Y / M M / D D)

Previous HPV Result: _____ __ __ __ __ / __ __ / __ __ (Y Y Y Y / M M / D D) **HPV Immunization Series completed?** ☐ Yes ☐ No

☐ Hysterectomy (Cervix removed)
☐ IUD
☐ OCP
☐ Pregnant _____ weeks
☐ Post partum _____ weeks
☐ Menopausal
☐ Hormone Replacement Therapy
☐ Immunocompromised
☐ First Pap following discharge from Colposcopy

RELEVANT CLINICAL HISTORY (please print clearly)

COLPOSCOPY CLINIC ONLY

☐ First colposcopy visit
☐ Pap taken at Colposcopy

IMPRESSION: ☐ Negative ☐ HPV/LSIL ☐ HSIL

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