Alberta Health Services

Non-Gynecological Cytology Requisition

(Sample Referral to Red Deer Hospital Laboratory)

Accession # *(lab only)*

Patient

PHN	Alternate Identifier		Date of Birth *(yyyy-Mon-dd)*	
Last Name	First Name	Middle	Gender ☐ M ☐ F	Phone
Address	City/Town	Prov	Postal Code	Location

Requestor (s)

Requestor Name *(last, first)*	Copy to *(last, first)*	Copy to *(last, first)*
Location/Facility/Address	Location/Facility/Address	Location/Facility/Address
Phone	Phone	Phone
Healthcare Provider ID	Healthcare Provider ID	Healthcare Provider ID

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

History - Required

☐ Previous Malignancy - PMA ☐ Hemoptysis - HEP ☐ Hematuria - HEM ☐ Bladder Tumor - BT
☐ Other - OT _____

Therapy

☐ Radiation - RA ☐ Not Provided - NP
☐ Chemotherapy - CH ☐ Other - OT _____

Additional Testing

☐ Pneumocystis (PJP) ☐ Flow Cytometry ☐ Cell Count ☐ CD4/CD8

Comments/Additional Information

Sample Source

Body Cavity Fluid - CYFL

☐ Pericardial - FPC ☐ Pleural - FPL ☐ Peritoneal - FPT ☐ Spinal - FSF ☐ Hydrocele - HY
☐ Other - OT _____

Urine - CYU

☐ Voided - V ☐ Catheter - CA ☐ Cystoscopy - CP ☐ Bladder Wash - BW ☐ Ileoconduit - IL

☐ **Sputum - CYSP**

☐ **Scraping/Lesion/Smear - CYSL**
☐ Site _____

Thyroid FNA - CYTH
☐ Isthmus - I ☐ Left - L ☐ Right - R

Breast FNA - CYBR
☐ Left - BRSL ☐ Right - BRSR

☐ **Excluding Breast and Thyroid FNA - CYFNA**
☐ Site _____

Nipple Discharge - CYND
☐ Left - L ☐ Right - R

☐ **Brushing - CYB** ☐ **Washing - CYW** ☐ **Lavage - CYBL**

Select site below

☐ Bile Duct - BD ☐ Bronchus Left - BL ☐ Bronchus Right - BR ☐ Esophagus - ESO
☐ Lingula - LG ☐ Lung Left Lower - LLL ☐ Lung Left Upper - LLU ☐ Lung Right Lower - LRL
☐ Lung Right Middle - LRM ☐ Lung Right Upper - LRU
☐ OT - Other _____

Sample containers ***Must*** be labeled with the following
■ Patient first and last name ■ Patient Unique Identifier ■ Sample type *(Source)*