ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Gynecological Cytopathology Requisition

Laboratory Information Center 403-770-3600
www.albertaprecisionlabs.ca

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	Phone	Phone
Clinic Name		Clinic Name	Clinic Name

Collection

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

Gynecological Specimen Site

☐ Cervix ☐ Vagina ☐ Anal

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.*

Clinical Information ***(please print clearly)***

LNMP
Date *(dd-Mon-yyyy)* _____

Cycle:
Every _____ days

Previous Pap Result _____
Date *(dd-Mon-yyyy)* _____

Previous HPV Result _____
Date *(dd-Mon-yyyy)* _____

HPV Immunization Series Completed?
☐ No ☐ Yes

☐ 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

For Lab Use Only