ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Non-Gynecological Cytopathology Requisition

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Scanning Label or Accession # *(lab only)*

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

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)*	Tissue Removed by *(Last, First Name)*	Date/Time Received	
Location/ Code/ Address (for report)	Collector ID	Phone	Fax

If other than routine: ☐ Priority *(clinical reason required - indicate below under "Clinical Information/History")*

Clinical Information/History *(check appropriate boxes and provide additional relevant information).* Lack of clinical information will delay results

- ☐ Previous Abnormal Pathology/ Malignancy *(specify)* ________
- ☐ Infection
- ☐ Previous Treatment

- ☐ Smoking
- ☐ Relevant imaging *(specify)* ________

Urine Cytopathology clinical presentation and history

- ☐ Bladder Tumor
- ☐ Gross Hematuria
- ☐ Microscopic Hematuria *(at least TWO microscopic urinalysis tests, performed at least one month apart, have both shown at least 3 RBC/high power field)*
- ☐ Bladder cancer surveillance, as advised by patient's Urologist

Other relevant Clinical History/Information – Specify

Specimen Source – *select all specimens that were collected and specify source, exact location, laterality, etc*

- ☐ Bronchial Brush ________
- ☐ Bronchial Wash ________
- ☐ Bronchoalveolar Lavage ________
- ☐ Sputum

- ☐ Pleural Fluid ________
- ☐ Peritoneal Fluid ________
- ☐ Fluid, Other *(specify)* ________
- ☐ CSF
- ☐ Other ________

- ☐ FNA - Salivary Gland ________
- ☐ FNA - Thyroid ________
- ☐ FNA – Lymph Node *(specify)* ________
- ☐ FNA – Other *(specify)* ________

- ☐ Urine – voided
- ☐ Urine – catheterized
- ☐ Urine – cystoscopy
- ☐ Urine – Other *(specify)* ________