### CYTOPATHOLOGY/GYNECOLOGICAL REQUISITION

**SATELLITE SITES**

**RESULTS REPORTING LOCATION CODE**

<table>
<thead>
<tr>
<th>Routine</th>
<th>Stat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ORDER DATE: __/__/____ (mm/dd/yyyy)

Ordering Clinician to receive report: [ ] See label above

UMHS Dr. #: __________

Attending Physician: (If different from above)

UMHS Dr. #: __________

### NON-GYNECOLOGICAL AND FINE NEEDLE ASPIRATION

LOCATION: [ ] Left  [ ] Right  [ ] Upper Lobe  [ ] Middle Lobe  [ ] Lower Lobe

**NON-GYNECOLOGICAL:** [ ] Scraping  [ ] Imprint

**FINE NEEDLE ASPIRATION**

ASPIRATION CYTOLOGY SERVICE: To request Fine Needle Aspiration, Cytopathology of palpable superficial lesions to be performed by the Cytopathologist, call 6-6799 or 6-6800. Use the Inpatient or Outpatient Consultation Referral Sheet and this requisition.

- [ ] Adrenal
- [ ] Breast
- [ ] Kidney
- [ ] Liver
- [ ] Lung
- [ ] Lymph Node: Specify location: __________
- [ ] Pancreas
- [ ] Salivary Gland: Specify Gland: __________
- [ ] Thyroid
- [ ] Transbronchial (Wang): Specify site: __________
- [ ] Other: Specify: __________

**RELEVANT HISTORY (SPECIMENS WITHOUT HISTORY NOT ACCEPTED)**

HAS PATIENT RECEIVED: [ ] Radiation  [ ] Cytotoxic Drugs  [ ] Please Explain:

### FOR PATHOLOGY USE ONLY

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Specimen Adequacy</th>
<th>Gross Description</th>
<th>Accession # CN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td># Slides</td>
</tr>
</tbody>
</table>

**GYNECOLOGICAL**

[ ] Screening Pap: This Pap test is part of the routine physical examination (NO patient complaints)

[ ] Diagnostic Pap: Patient has had previous abnormal test, findings, symptoms or significant complaints.

**Refractive HPV Test Requests (ThinPrep Only):** Specimen will be held 21 days for additional test requests.

Please Specify: [ ] If ASCUS Only  [ ] All Atypical/Abnormal Results  [ ] For All Results

**Specimen Type:** [ ] Cervical/Endocervical  [ ] Vaginal  [ ] Vulvar  [ ] Other __________

**RELEVANT HISTORY (SPECIMENS WITHOUT HISTORY NOT ACCEPTED):**

LMP: ____________  [ ] LMP Unavailable (*For women less than 50 years of age, an LMP or reasonable estimate of days or months must be provided.)

[ ] Pregnant: # Weeks: ____________  [ ] Post Partum: # Weeks: ____________  [ ] Postmenopausal

<table>
<thead>
<tr>
<th>IUD in place</th>
<th>Gynecological complaint</th>
<th>Abnormal cervix</th>
<th>Previous gynecologic surgery</th>
<th>Significant Nongynecological Diseases/Abnormalities</th>
<th>Previous Gynecological cancer</th>
<th>Chemotherapy</th>
<th>Hormonal Therapy</th>
<th>Radiation Therapy</th>
<th>Previous Abnormal Pap Smear</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
</tr>
</tbody>
</table>

**M.D. Code**

Accesion # CG [ ] Slides

**C.T.**

# Slides

**FINAL REPORT DX:**

---

**2201614**  
**Rev. 10/06**  
**WHITE - SPECIMEN PROCESSING**  
**YELLOW - CLINIC**  
**CYTOPATHOLOGY / GYNECOLOGICAL REQUISITION - SATELLITE SITES**