

# CERVICAL CYTOLOGY REQUEST FORM

**Send specimen to:**

- Health Sciences Centre Cytology Laboratory**  
 820 Sherbrook St (MS337), Winnipeg, MB R3A 1R9  
 P: 204-787-1352 F: 204-787-1790
  - Westman Laboratory**  
 Unit 1-150 McTavish Ave, E, Brandon, MB R7A 7H8  
 P: 204-578-4440 / 1-800-661-5458 Ext. 4467  
 F: 204-578-2819
  - St. Boniface Hospital Cytology Laboratory**  
 409 Taché, Winnipeg, MB R2H 2A6  
 P: 204-237-2504 F: 204-235-3423
- Dynacare**  
 830 King Edward St, Ste #100, Winnipeg, MB R2H 0P4  
 P: 204-944-0757 F: 204-957-1221

<b>Accession #</b>	<b>Date received (dd/mmm/yyyy)</b>	<b>Specimen collection date (dd/mmm/yyyy)</b>
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**PATIENT INFORMATION**  
\* Matching PHIN and first and last name required on vial

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Last name First name

.....

PHIN (or military, other prov/terr #) MB Health #

.....

F  M

Date of birth (dd/mmm/yyyy) Gender 3<sup>rd</sup> party billing

.....

Address

.....

City Prov Postal code

**PATIENT HISTORY**

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Last normal menses (dd/mmm/yyyy) Last Pap test (dd/mmm/yyyy)

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Previous abnormal Pap test (dd/mmm/yyyy)

Pregnant  Postpartum \_\_\_\_\_ (# weeks)

Menopausal  Postmenopausal

**PREVIOUS TREATMENT:**

Colposcopy  Laser  Cryotherapy  LEEP

Knife cone  Irradiation  Wide local excision

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Date (dd/mmm/yyyy)

<b>HYSTERECTOMY:</b>	Previous cancer
<input type="checkbox"/> Total <input type="checkbox"/> Subtotal	

**PRESENT TREATMENT:**

Hormonal:  HRT  OCP  IUCD

**COMMENTS:**

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**SPECIMEN PREPARATION:**

Liquid based cytology  Conventional cytology

**INSTRUMENT(S):**

Broom  Spatula  Cytobrush

**SOURCE:**

Cervix  Vagina

**SPECIMEN COLLECTOR INFORMATION**

.....

Last name First name

.....

CervixCheck/Provider # Bill to (#)

.....

Send report to (street address)

.....

City/Town Prov Postal code

.....

Phone Fax

.....

Copy report to (name)

.....

Address

.....

**DESIGNATION:**

Physician  Nurse practitioner  Nurse

Physician assistant  Clinical assistant  Midwife

**Specimen collector should identify themselves on the form as follows:**

DESIGNATION	CERVIXCHECK/PROVIDER #:	BILL TO (#):
Clinical assistant	22### (CervixCheck provider #)	Physician or NP billing #
Midwife	Not applicable	Billing #
RN(NP)	Not applicable	Billing #
RN, RN(AP), RPN	N### (CervixCheck provider #)	Physician or NP billing #
Physician	Not applicable	Billing #
Physician assistant	72### (CervixCheck provider #)	Physician or NP billing #