Dynacare

CYTOLOGY TESTING REQUISITION

Client ID: 609520

Brant Community Healthcare System
200 Terrace Hill St.,
Brantford, ON N3R 1G9
(519) 751-5544 ext 2440

Laboratory Use Only

Ord Phy:
CC Doctor(s):

Clinician Phone Number	Patient Chart Number	
Health Card Number(HCN)	Sex	Date of Birth
Province	Patient Phone No.	
Patient Last Name	Patient Location	

BCHS LAB NO: _____

Patient First Name

Patient Address

NON-GYNECOLOGIC CYTOLOGY

Specimen Collection Date: _____

Urine: [_] Voided [_] Cysto [_] Catheterized [_] Bladder Wash
Respiratory: [_] Sputum [_] Bronchial Brush [_] Bronchial Was**h**
Site/Side(if applicable): _____

Fluids: [_] Pleural [_] Peritoneal [_] CSF [_] Joint [_] Pericardial [_] Other(specify)_____
Site/Side (if applicable): _____ Total Volume in mls (pericardial/peritoneal/pleural): _____

Thyroid: [_] Left [_]Right [_] Cyst [_]Nodule [_] Single [_] Multiple
Breast: [_] Left [_] Right [_] Cyst Fluid [_] FNA of Mass [_] Nipple Discharge

Fine Needle Aspiration Biopsy: [_] Left [_] Right
[_] Kidney [_] Salivary Gland [_] Lung [_] Liver [_] Lymph Nodes(specify)_____ [_]Neck
[_] Pancreas [_] Pelvic mass [_] Other(specify)_____

Other Site(specify):

Clinical History/Remarks:

Has the patient received: Radiation? _____ Chemotherapy? _____
Peritoneal Specimens: History of Cirrhosis? [_] Yes [_] No [_] Unknown
Previous negative peritoneal cytology within the last year? [_] Yes [_] No [_] Unknown
Clinical indication for peritoneal cytology: [_] Concern for malignancy [_] Changing clinical features
Special Request to Cytology Lab:

Laboratory Only
Cell Block Request:
[_] Yes [_] No

(BCHS-Laboratory Use)
Specimen Rec'd Date:_____ Time:_____ Initials:_____
Specimen Description: Colour: _____ Clarity:_____
Received in Cytolyt : Yes No Volume:_____
Preservative added by MLA: Yes No
Date added:_____ Time:_____ Initials:_____
Number of Slides Received: _____