MedStar Georgetown
University Hospital

PATIENT LABEL

CYTOPATHOLOGY REQUISITION

(Please use one form per specimen)

GUH 80620000 (4/26/13) (F3F)

GUH80620000

DATE OF COLLECTION	TIME OF COLLECTION	

PATIENT NAME		MRN #	ACCOUNT #
DATE OF BIRTH	GENDER	**REQUESTING PHYSICIAN (Full Name)**	
ADDRESS		**REFERRING PHYSICIAN (Full Name)**	
INSURANCE INFORMATION *(Provide Copy of Insurance and ID Card)*		**ICD-9 CODE (Required)**	

CLINICAL DATA (Required)

PROCEDURE _____

TYPE OF SPECIMEN:

GYN: *Date of last menses (required for GYN)* _____

Source: ❑ Vaginal ❑ Cervical ❑ Other: _____

Test: ❑ Pap Only ❑ Reflex HPV Testing ❑ Cotesting ❑ Other: _____
❑ Gonorrhoeae Nucleic Acid Amplification ❑ Chlamydia Nucleic Acid Amplification

RESPIRATORY:
❑ Sputum ❑ Induced Sputum ❑ Bronchoalveolar Lavage: ❑ L ❑ R ❑ Bronchial Brush: ❑ L ❑ R

GASTRO-INTESTINAL:
❑ Esophageal Brushing ❑ Biliary Brushing ❑ Other *(specify)* _____

URINARY:
❑ Bladder Washing ❑ Voided Urine ❑ Catheterized Urine ❑ Ureter Wash: ❑ L ❑ R

FLUID:
❑ Pleural: ❑ L ❑ R ❑ Ascitic ❑ Pericardial ❑ CSF
❑ Gutter Wash: ❑ L ❑ R ❑ Pelvic Wash ❑ Other *(specify)* _____

FNA: *(Specify Site)* _____

❑ EBUS / TBNA *(check if applicable)*

AREA BELOW FOR LAB USE ONLY

Gross Description:

Received _____ mls of _____ *(color, appearance).*

❑ Vial of Preservcyt ❑ Vial of Cytolyt ❑ Air-dried smear # _____ Other _____

Preparation:
❑ Diff-Quik-stained direct smear (# _____)
❑ Diff-Quik-stained cytospin
❑ Diff-Quik stained ThinPrep
❑ Papanicolaou stained ThinPrep smear
❑ Cell Block
❑ Other _____

Date Specimen Processed _____ Prepared By _____