CYTOPATHOLOGY CONSULTATION REQUEST

MUSC Health
LABORATORY SERVICES

165 Ashley Avenue, Room EH318 Charleston, SC 29425
Phone (843) 792-2171
Fax (843) 792-8974

Ordering Location: ______________________
Phone #: ______________________________

Place patient identification label / Epic Registration label

1. Complete Patient Demographic Information if patient identification or IDX label is not available

Patient Name (Last, First, MI)			THIS AREA FOR LAB USE
DOB	Sex	Race	Accession Number: ______________
MRN	PATCOM#		Received Date / Time: ______________

2. Complete General Specimen Information

Collection Date: ____________

Collection Time: ____________

Ordering Physician Full Name (Please Print) *(Required)*

____________________________ Pager ID __________

Ordering Physician Signature

____

Gynecologic
☐ Vaginal
☐ Cervical/Endocervical
☐ Vulva
☐ Other ______________

Respiratory
☐ Sputum
☐ Bronchial Wash (R / L)
☐ Bronchial Brush (R / L)
☐ Bronchiolo-Alveolar Lavage
(R / L) Site ______________

Body Cavity
☐ Pleural (R/ L) __________
☐ Pericardial ☐ Ascitic
☐ Peritoneal Wash
☐ Other ______________

FNA
☐ Superficial ☐ CT
☐ Ultrasound ☐ EUS
☐ Bronchoscopy ☐ OR
☐ RT ☐ LT
Site ______________

Gastrointestinal
☐ Esophageal ☐ Gastric
☐ Colon ☐ Bile Duct
☐ Other ______________

Cerebral Spinal Fluid
☐ Lumbar Puncture
☐ Ventricular Fluid
☐ Other ______________

Urinary
☐ Urine Voided ☐ Urine Catheterized
☐ Bladder Wash ☐ Ureter (R / L)
☐ Renal Pelvis (R / L)
☐ Conduit
☐ Other ______________

Miscellaneous
☐ Cyst
☐ Other ______________

Breast
☐ Nipple Discharge (R / L)

3. Complete Information Required for Proper Evaluation

REQUIRED FOR PAP SMEAR PATIENTS: (SELECT ONE)
☐ SCREENING PAP ☐ DIAGNOSTIC PAP

REQUIRED: ICD10 CODE ______________

History: (Pertinent clinical findings and diagnoses)
____
____

4. Clinical Information and Ancillary Testing

G: P: A: LMP: ☐ Regular ☐ Irregular

GYN

If yes, list any additional information below
1. Pregnant ☐ no ☐ yes ______________
2. Post-partum ☐ no ☐ yes ______________
3. Abnormal bleeding ☐ no ☐ yes ______________
4. Birth control pills ☐ no ☐ yes ______________
5. IUD ☐ no ☐ yes ______________
6. Menopause ☐ no ☐ yes ______________
7. Endocrine therapy ☐ no ☐ yes ______________
8. Hysterectomy ☐ no ☐ total ☐ subtotal ☐ radical
9. Oophorectomy ☐ no ☐ unilateral ☐ bilateral ☐ unknown

ALL TYPES

10. Previous cytology
☐ no
☐ yes by MUSC, date: ______________
☐ yes by Other-site, date, dx ______________
11. Tissue exam, surgery ☐ no ☐ yes ______________
12. Chemotherapy ☐ no ☐ yes ______________
13. Radiotherapy ☐ no ☐ yes ______________

High-risk (HR) Human Papillomavirus (HPV) DNA testing
☐ High-risk HPV DNA testing if Cytology Negative or ASC-US
☐ High-risk HPV DNA testing if Cytology Negative or ASC-US with reflex to HPV 16/18 genotype test if Cytology Negative and HR/HPV positive
☐ Reflex high-risk HPV DNA testing if ASC-US
☐ High-risk HPV DNA testing for other reasons (Please specify) ______________________________