

DOWNTIME ANATOMIC PATHOLOGY REQUISITION

**NewYork-Presbyterian
Brooklyn Methodist Hospital**
506 6th Street Brooklyn, NY 11215
Phone: 718-780-3640



Affix EPIC Patient Label Here

For more information, visit the Lab Test Directory:

| Patient Information | | | Ordering Provider |
|--|----------------------------------|-----------------|---------------------|
| Last Name: | First Name: | MI: | Provider Name: |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth: ____/____/____ | MRN#: | Provider Signature: |
| Patient Unit Location: | Unit Phone #: | Unit Fax #: | Provider CWID: |
| Collector Name: | Collector Title: | Collector CWID: | Provider Phone: |
| Collection Date: | Collection Time: | ICD-10 Codes: | Order Date & Time: |

Note: All the above fields are mandatory to complete.

REQUIRED: Significant clinical history, including known cytology and surgical pathology diagnosis or differential diagnosis _____

Treatment:

- None Cautey Surgery Radiation Chemotherapy Hormonal
 Others _____

Surgical Pathology

| | Specimen Source: Laterality (L/R), Organ, Procedure (Biopsy, excision, resection, etc.) | Time Placed in Formalin | | Specimen Source: Laterality (L/R), Organ, Procedure (Biopsy, excision, resection, etc.) | Time Placed in Formalin |
|----|---|-------------------------|----|---|-------------------------|
| A. | | | E. | | |
| B. | | | F. | | |
| C. | | | G. | | |
| D. | | | H. | | |

Cytology - GYN

LMP: _____ **Hysterectomy :** Supracervical Total

Specimen Source: Vaginal Cervical Endocervical ThinPrep Pap Conventional Smear

PAP: Screening Diagnostic Previous abnormal PAP History: _____

Additional Orders [Only for ≥21 years old]: HPV Test HPV Reflex only if abnormal PAP HPV Genotyping

Cytology - Non GYN

Specimen Source

Ascites Pleural CSF BAL Sputum Pericardial RT LT

Others: _____ RT LT

Brushing: _____ RT LT

Washing: _____ RT LT

Urine: Voided Catheterized Other _____

Fine Needle Aspiration[FNA]

Site: U/S CT EUS EBUS TBNA

Size: _____ Cyst Solid Solid/Cyst RT LT

Specimen Source: _____ **Number of Smears:** _____

Additional Studies: _____

CONTACT THE LABORATORY FOR ASSISTNACE WITH ORDERING THE FOLLOWING SENDOUT TESTS:

WEILL CORNELL

- Hematopathology Comprehensive
- Flow Cytometry Only
- Renal
- Consultation
- Neuro

COLUMBIA

- Cytogenetics Post Natal
- Cytogenetics SNP Oligonucleotide Microarray Analysis (SOMA)
- Cytogenetics SOMA Control
- Cytogenetics, Bile Duct Brushings (FISH Only)
- Muscle kit
- Nerve Kit

**Internal Lab Use
(Fix Labels here)**