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Gynecological Cytopathology Request

For lab use only

Date Received: ..... Initial: .....

Time Received: ..... Accession#:

Patient Information

Name: .....

ID/CPR: ..... Nationality: .....

DOB: (dd/mm/yyyy) ..... ☐ Male ☐ Female

Phone: .....

Treating Physician

Name: .....

Facility/Institution: .....

Signature: .....

Stamp: .....

Specimen Information

Specimen Source: ☐ Cervical ☐ Vaginal Vault ☐ Vulvar

☐ Other (Specify): .....

Test(s) Requested

☐ PAP Smear ☐ HPV Molecular Studies

☐ Other (Specify): .....

Clinical Information

- ☐ Date of Last Menstrual Period ____ / ____ / ____
- ☐ Pregnant / Post - Partum
- ☐ IUCD
- ☐ Post - Menopausal
- ☐ Hysterectomy: Sub-Total
- ☐ Hysterectomy: Total
- ☐ Other (Specify): _____

Clinical History

- ☐ Cancer / Dysplasia
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Irregular Menstrual Bleeding
- ☐ Post Menopausal Bleeding
- ☐ Hormone Therapy
- ☐ Colposcopy / Biopsy
- ☐ Other (Specify): _____

Symptoms and Dx being considered

Required

Form completed by: .....

Date: ..... Phone: .....

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