Your Hospital's Logo Here

IN Request **IN** Specimen

P T #											AGE / SEX ☐ M ☐ F

NAME:		DATE OF BIRTH:
ADDRESS:		
CITY:	STATE:	ZIP:
PHYSICIAN:		
INSURANCE CO:	POLICY #:	

CYTOLOGY

DATE ORDERED:	DATE DONE:	
SOURCE: ☐ CERVICAL ☐ VAGINAL ☐ COMBINED C / V		
FLUID (Site):		
DOB:	LMP:	HORMONES:
IUD:	REPRODUCTIVE STATUS:	ADDITIONAL STUDIES: ☐ MATURATION INDEX ☐ OTHER (Describe)
PREVIOUS CYTOLOGY THERAPY (Dates & Results)		

CLINICAL FINDINGS:

INFORMATION BELOW FOR OFFICE USE ONLY

CELL PATTERN	☐ PARABASAL ☐ INTERMEDIATE ☐ SUPERFICIAL ☐ ENDOCERVICAL CELLS ☐ ENDOCERVICAL COMPONENT ☐ ENDOCERVICAL CELLS + ABSENT COMPONENT ☐ SQUAMOUS METAPLASIA ☐ OTHER (Describe)
ORGANISM	☐ TRICHONOMAS ☐ YEAST ☐ BACTERIA ☐ HERPES ☐ CHLAMYDIA
CANCER SCREEN	☐ NO ATYPICAL CELLS (Negative) ☐ OTHER (See Below) ☐ MALIGNANT (See Below) ☐ UNSATISFACTORY (See Below)

COMMENTS

SCREENED: CT		PATHOLOGIST: MD
DATE:	# OF SLIDES / SPECIMENS:	SPECIMEN #: