مختبرات ثومبي
THUMBAY LABS
REFERRAL • RESEARCH • INNOVATION

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

ثومبي THUMBAY
Growth Through Innovation

| Accession No<br>Name of client | TRF No | Billing code: | Insured:Y/N<br>Company: |
|---|---|---|---|
| | | Priority: Routine/ Urgent | |

# CYTOPATHOLOGY REQUISITION FORM - (GYNECOLOGICAL SPECIMEN)

Second name: First name: Date of Birth/Age: Sex:

Ethnic origin: Marital Status: Occupation:

Hospital/ Clinic: Hospital Registration No. (OPD/IP): Ward/ Room No:

Requesting Physician: Physician-in-charge & Dept:

Phone No: Fax No:

Specimen submitted: Date:

Fixative used:

Conventional/ Liquid based cytology

Clinical Information:

Complaints:

Menstrual history:

LMP:

No. of children:

Last child birth:

Intrauterine device:

H/o hormone therapy / OCP:

BMI:

PV examination findings:

Colposcopic findings, if any:

Pelvic US findings:

Any past history like tumor radiation / Surgery / Electrotherapy

Provisional diagnosis/Differential diagnoses

Previous biopsy: Yes ☐ No ☐

If yes, provide diagnosis and Biopsy accession no:

Previous Cytological diagnosis: Yes ☐ No ☐

If Yes , provide diagnosis and cytology accession no: Signature of the Physician

| PATIENT | | | |
|---|---|---|---|

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Fixative:

Date of receipt of specimen:

Label: Information matches with that of requisition form: Yes ☐ No ☐

Technologist:

Name & Signature:

## FOR LAB USE ONLY

Accession No:

| Date of Preparation: | Prepared By: |
|---|---|
| Gross Examination: | No of smears ☐<br>Cell Block ☐<br>Stock Kept ☐ |

Description:

- Satisfactory / Unsatisfactory
- Endocervical component
- Inflammatory Cells
- Dysplastic Cells
- Lactobacilli

Diagnosis:

Signature of Pathologist

Date: