



Hospital & Clinics

NON- GYNECOLOGIC CYTOLOGY REQUISITION AND SERVICE RECORD CYTOLOGY – 051

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ACCOUNT NO.

MED. REC. NO.

NAME

BIRTH DATE

SEX

Stamp Patient Card Here

REQUESTING PHYS. NAME	PHYS. NUMBER	CYTOLOGY ACCESSION NO	REQ LOC	DX CODE PRIMARY _____ SECONDARY _____
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Special Instructions: _____

MAIL CODE

BODY SITE _____ REASON FOR PROCEDURE _____

SPECIMEN TYPE: _____

Pertinent History and Clinical Diagnosis: _____

HIPAA Required Data:

Date of current onset _____

Date of similar symptom _____

If Pregnant Y / N LMP _____ estimated due date _____

Comment: _____

C.T. _____ DATE _____ PATHOLOGIST _____