OHSU Health
Hospital & Clinics

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTH DATE SEX

Stamp Patient Card Here

NON- GYNECOLOGIC CYTOLOGY DOWNTIME REQUISITION

REQUESTING PHYS. NAME	PHYS. NUMBER	CYTOLOGY ACCESSION NO	REQ LOC	DX CODE PRIMARY_____ SECONDARY_____

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 _____

Results will be immediately available to the patient unless you mark the box below:

□ Do not release (I reasonably believe that an Information Blocking exception applies)

Comment: _____

_____

_____

_____

_____

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_____

_____

_____

C.T. _____ DATE_____

PATHOLOGIST_____