CYTOLOGY AND HPV REQUEST FORM (2023)

Provincial Clinical Laboratory

Queen Elizabeth Hospital, Charlottetown, PEI
Phone: (902) 894-2300 Fax: (902) 894-2385

Address for Non-PEI Residents Required

Name: _____

Street: Place Label Here

City: _____ Prov./State: _____

Postal Code/Zip: _____

Payment Responsibility ☐ WCB ☐ DVA ☐ DND ☐ RCMP ☐ Self Pay Canadian ☐ Self Pay Non-Canadian Provincial Medicare # exp. date:	**DOB: YYYY-MMM-DD**	Sex	Medical Record Number (MRN)

Location	Copies to (Fax # required for out of province providers) FIRST & LAST NAME	Copy to ☐ Cervical Cancer Screening Program

Date Specimen Obtained: YYYY/MMM/DD

Gynecological Specimen

Sample Site:

☐ Cervix

☐ Vaginal vault, post hysterectomy (Pap test only)

Test Requested:

☐ HPV for cervical cancer screening

☐ Pap test (liquid based) indications:

- ☐ Follow-up of previous positive HPV test (i.e. self-sampled)
- ☐ During colposcopic exam
- ☐ Abnormal uterine bleeding
- ☐ Post menopausal bleeding
- ☐ Abnormal discharge
- ☐ DES exposure in utero
- ☐ Other: _____

Additional Clinical Information:

Date of Last Menstrual Period (LMP): YYYY/MMM/DD

- ☐ Immunocompromised
- ☐ Post menopausal
- ☐ Pregnant
- ☐ Postpartum
- ☐ Hormone therapy
- ☐ IUD
- ☐ Pelvic radiation
- ☐ Previous abnormal Pap test, biopsy, or HPV test

(detail in clinical findings below if out of province)

Non-Gynecological Specimen

☐ **Sputum**

Urine: ☐ Voided ☐ Catheter ☐ Bladder Washing ☐ Cystoscopy ☐ Other (Specify)

Bronchial *(Specify Site)*: _____ ☐ Washing ☐ Brushing ☐ Bronchoalveolar Lavage

Test: ☐ Cytology ☐ Cell Count ☐ Pneumocystis

☐ **Pleural Fluid** ☐ **Peritoneal Fluid** ☐ **Pericardial fluid**

☐ **Pelvic Washing** ☐ **Other GYN Staging Site *(Specify)*:**

☐ **Fine Needle Aspirate (FNA) - *Specify Site:*** ☐ **Other - *Specify:***

Clinical Findings:

Collecting Clinician (Required and Please Print)
FIRST & LAST NAME

Collecting Clinician Signature (Required)