

NON-GYNECOLOGIC CYTOLOGY REQUISITION

University of Colorado Anschutz Medical Campus - Department of Pathology (Division of Cytology)
Mail Stop F-779, AIP Building, Room 3.136, 12605 E. 16th Avenue, Aurora, CO 80045 (<http://pathology.ucdenver.edu>)

Phone: 720-848-4361
Fax: 720-848-0924

Ordering Clinician

Last Name: _____ UPIN #: _____

First Name: _____ Pager Number: _____

Resident / Clinic Contact Individual: Name _____

Phone #: _____

Clinic Information

AIP ACP AOP Satellite Other _____

Clinic Name: _____

Clinic Address: _____

Clinic Phone #: _____ Fax #: _____

Medical Record Number:

Patient Name (Last, First, MI): _____

DOB: _____

Sex: _____

Encounter/Visit No.: _____

Referral #: _____

Ins Payor Code:

Registered

In-Patient

Non-Registered

Out-Patient

Attach patient data sheet and insurance card
(Charges may be billed directly to client, if not provided)

Prior Malignancy Yes No Specify: _____

Chemotherapy Yes No Specify: _____

Radiation Therapy Yes No Specify: _____

INFECTIOUS / RESPIRATORY PRECAUTIONS

Specify: _____

Containers Sent: _____

Routine

STAT

Date Collected: _____ Time Collected: _____

Collected By: _____ Phone #: _____

GLASS CONTAINERS, LARGE PLEURA-VAC CONTAINERS, SYRINGES W/NEEDLES, OR EXCESSIVE AMOUNTS (<500 ML) WILL NOT BE ACCEPTED

<input type="checkbox"/> CSF	<input type="checkbox"/> Urine (Voided)	<input type="checkbox"/> Pericardial Fluid	<input type="checkbox"/> Other (Specify): _____
<input type="checkbox"/> Sputum (Must be fixed)	<input type="checkbox"/> Urine (Catheterized)	<input type="checkbox"/> Pleural Fluid	_____
<input type="checkbox"/> Bronchial Washing	<input type="checkbox"/> Bladder Washing	<input type="checkbox"/> Peritoneal Fluid	
<input type="checkbox"/> Bronchial Brushing	<input type="checkbox"/> Bile Duct Brushing	<input type="checkbox"/> Pelvic Washing	
<input type="checkbox"/> Bronchial Alveolar Lavage	<input type="checkbox"/> Pancreatic Brushing	<input type="checkbox"/> ANAL Pap	

Additional Testing / Procedures

GMS AFB

Other: _____

PLEASE PROVIDE CLINICAL INDICATIONS, DIAGNOSIS (Dx Code), HISTORY, COMMENTS

DO NOT WRITE BELOW THIS LINE -- LAB USE ONLY

# Containers Received _____ Amount Received _____ ml <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Bloody Color: _____ # of Slides Received _____	Thin Prep			Accession Number: _____ Date Received: _____ Time Received: _____ Processed By: _____
	Prep Smears (DQ)			
	Prep Smears (Pap)			
	Cell Block (H&E)			
	Cytospins			
	Special Stains			
	Total # of Slides			