Cayuga HEALTH

Department of Laboratories
Elizabeth Plocharczyk, M.D.
Director of Laboratories

Non - GYN Cytology Order

Cytology #

PATIENT/PROVIDER INFORMATION
Print or Affix Label

Last	First	MI
Street		
City	State	Zip
Proceduralist Signature	Date/Time	
☐ Verbal Order taken & Read back by: (signature)		(date/time)

DOB ☐ Male ☐ Female

Account #

Date/Time Collected

Copies To:

☐ Bill Insurance (attach copy of insurance card)
☐ Self Pay

Adequate clinical information is essential for accurate cytological interpretation.

Clinical Diagnosis - History - Symptoms (required)

Diagnosis Code: _____

Reason for Test: _____

_____

Previous Malignancy: ☐ Yes ☐ No

If Yes, Date & Type: _____

Previous Radiation: ☐ Yes ☐ No Date: _____

Previous Chemotherapy: ☐ Yes ☐ No Date: _____

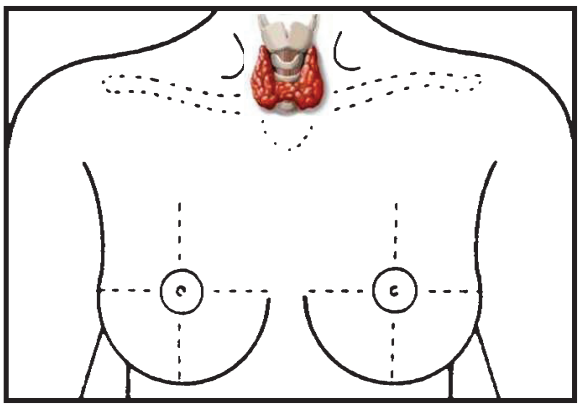
SPECIMEN TYPE / SOURCE

Respiratory
☐ Bronchial Lavage/Wash Site: _____
☐ Bronchial Brush Site: _____
☐ Sputum
☐ Other: _____
Site

Urinary ☐ with reflex to UroVysion, if atypical.
☐ Urine - Catheterized
☐ Urine - Voided
☐ Bladder Wash
☐ Other: _____
Site

Body Fluid
☐ Cerebrospinal Fluid
☐ Pleural
☐ Peritoneal
☐ Other: _____
Site

Fine Needle Aspiration
☐ Breast ☐ Right ☐ Left
☐ Thyroid ☐ Right ☐ Left ☐ Isthmus
☐ Other: _____
Site



For Lab Use Only:
Gross:

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