Reset Form

fraserhealth

OUTPATIENT CYTOPATHOLOGY REQUISITION

Royal Columbian Hospital phone (604) 520-4352
330 E Columbia St. fax (604) 520-4409
New Westminster, BC V3L 3W7

Patient name: _____ (Last) _____ (First)

Date of Birth: _____ (DD/MM/YYYY) Sex: ☐ M ☐ F

PHN: _____ Insurance: MSP

MSP
Self pay
Out of prov
WCB
RCMP
Veterans
Refugee

Ordering Physician: _____ (Name) _____ (MSP Number)

Patient Address: _____ City: _____

Province/State: _____ Country: _____ Postal Code: _____ Phone: _____

Additional copies to: _____ (Name & MSP number) _____ (Name & MSP number) _____ (Name & MSP number)

Relevant Clinical History/ Diagnosis:

Date of procedure: _____ (DD/MMM/YYYY)

Physician signature or stamp: _____

Specimen Site:

Urine: ☐ Catheter ☐ Voided

Bronchial: ☐ Washing ☐ Brush

- ☐ Sputum
- ☐ Pleural
- ☐ Peritoneal fluid/ Ascites
- ☐ Pericardial
- ☐ Abdominal / Peritoneal washing
- ☐ Gastric / Esophageal
- ☐ Bile duct brushing
- ☐ Synovial fluid
- ☐ Nipple discharge
- ☐ CSF
- ☐ Other _____

Laboratory Use Only:

Tissue Code:	Accession Number:
URC/URV	
BW/BB	
SPUT	Technologist Comments:
PLF	
PTF	
PER	
ABD	
GAS	Pathologist Diagnosis:
CBD	
JOI	
ND	
CSF	
OT	