



**OUTPATIENT  
CYTOPATHOLOGY REQUISITION**

Royal Columbian Hospital phone (604) 520-4352  
330 E Columbia St. fax (604) 520-4409  
New Westminster, BC V3L3W7

Patient name: \_\_\_\_\_  
Last First

Date of Birth: \_\_\_\_\_ Sex:  M  F  
DD/MM/YYYY

PHN: \_\_\_\_\_ Insurance: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_  
Name MSP Number

MSP  
Self pay  
Out of prov  
WCB  
RCMP  
Veterans  
Refugee

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: \_\_\_\_\_ Physician signature or stamp: \_\_\_\_\_  
DD/MMM/YYYY

**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	