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OUTPATIENT CYTOLOGY FINE NEEDLE ASPIRATE REQUISITION

Reset Form

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)

Hospital ☐ ARH ☐ BH ☐ RCH ☐ SMH

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:

Physician signature or stamp: _____

Procedure Date: _____ (DD/MM/YYYY) FNA Performed By: _____ Assisted By: _____

Note: 2 smear slides per aspirate site
1 needle rinse container per aspiration site, DO NOT combine sites

#	Site Aspirated	Number of smears prepared	Number of needle rinse containers	Comments
1	☐ FNA SITE: ☐ RT ☐ LT _____ ☐ EBUS STATION _____ ☐ EUS _____			
2	☐ FNA SITE: ☐ RT ☐ LT _____ ☐ EBUS STATION _____ ☐ EUS _____			
3	☐ FNA SITE: ☐ RT ☐ LT _____ ☐ EBUS STATION _____ ☐ EUS _____			

Collection Fluid: ☐ FORMALIN ☐ PLASMA LYTE ☐ CYTOLYT ☐ OTHER _____

For Laboratory Use Only: