SURGICAL PATHOLOGY AND CYTOLOGY REQUISITION

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Patient Demographics

PATIENT NAME (Last) (First) (MI)

DATE OF BIRTH | GENDER: ☐ MALE ☐ FEMALE

ADDRESS

CITY STATE ZIP

HOME PHONE SOCIAL SECURITY #

Ordering Physician Information

NAME & CREDENTIALS (Printed)

PHYSICIAN SIGNATURE

PRACTICE NAME AND ADDRESS PHONE:

COPY RESULTS TO:

Clinical History / Diagnosis / Operative Findings

Insurance Details (Please attach copy of insurance card, front & back)

ICD-10 (Required) 1._____ 2._____ 3. _____

Collection Information

COLLECTOR:_____ DATE: _____/_____/_____ TIME:_____

SURGICAL PATHOLOGY TISSUE SPECIMENS (Additional Specimen IDs on back)

Specimen ID	Specimen Site / Description	Procedure	Removal Time	Time into Formalin
A				
B				
C				
D				
E				
F				

GYN CYTOLOGY (PAP TEST)

Last Menstrual Period (LMP): _____/_____/_____ SOURCE: ☐ CERVIX ☐ VAGINA ☐ Other:_____

Test Requested (select one):

- ☐ Pap Only
- ☐ Pap + HPV (Any Diagnosis)
- ☐ Pap + HPV (Reflex if ASC-US)
- ☐ HPV Only

Additional Tests Available:

- ☐ Chlamydia and Gonorrhea Screen
- ☐ Trichomonas Screen

Current Clinical Findings:

- ☐ Abnormal or Postmenopausal Bleeding
- ☐ Breastfeeding
- ☐ BCPs / Depo Provera
- ☐ Estrogen / Hormonal Therapy
- ☐ IUD
- ☐ Patient's First Pap
- ☐ Postmenopausal
- ☐ Post Partum
- ☐ Pregnant
- ☐ Radiation / Chemotherapy
- ☐ Supracervical Hysterectomy
- ☐ Total Hysterectomy
- ☐ Visible Lesion on Pelvic Exam

Previous Abnormal Findings:

- ☐ Last Pap - ASC-US/HPV+
- ☐ Previous ASC-H (past 5 years)
- ☐ Previous Atypical Glandular Cells
- ☐ Previous Cancer (Cervical)
- ☐ Previous Cancer (Ovarian)
- ☐ Previous Cancer (Uterine/Endometrial)
- ☐ Previous HPV Genotype 16 or 18/45+
- ☐ Previous HPV+ (past 5 years)
- ☐ Previous HSIL
- ☐ Previous LSIL (past 5 years)
- ☐ Other: _____

NON-GYN CYTOLOGY

URINE SOURCE: ☐ Voided ☐ Catheterized ☐ Cystoscopic ☐ Bladder ☐ Kidney, Right ☐ Kidney, Left ☐ Other:_____

☐ Abscess ☐ Body Fluid ☐ Bronchial Lavage ☐ Brush ☐ CSF ☐ Cyst ☐ Fine Needle Aspirate (FNA) ☐ Smear/Scrape ☐ Sputum ☐ Wash

SOURCE:_____ ☐ Right ☐ Left Air-Dried Slides # _____ Fixed Slides # _____

Lab Use: Volume Received:_____ Specimen Description upon receipt:_____

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ADDITIONAL SURGICAL SPECIMEN INFORMATION

Specimen ID	Specimen Site / Description	Procedure	Removal Time	Time into Formalin
G				
H				
I				
J				
K				
L				
M				
N				
O				
P				
Q				
R				

SURGICAL SPECIMEN REQUIREMENTS

✹ **Specimen Containers:**

- If more than one container, each container must be recorded sequentially and lettered.
- Each container must contain 2 patient identifiers.
- For adequate fixation, formalin volume should be at least 10 times specimen size.

✹ **Clinical History and Operative Findings:**

- Provide the appropriate ICD code for testing.
- Provide any relevant history and clinical information for optimal diagnostic interpretation and insurance/billing.

✹ **Removal Time / Time into Formalin:**

- **ALL routine surgical specimens should be submitted in 10% buffered formalin.**
- Removal time - the time the specimen was surgically removed from the patient.
- Time into formalin - the time the specimen was placed into 10% buffered formalin.
- Specimens should be placed into formalin within 60 minutes of removal.

WELLSPAN PATHOLOGY LABORATORY LOCATIONS

YORK	ADAMS	LANCASTER	LEBANON
York Hospital 1001 South George St. York, PA 17403 Phone: (717) 851-5001 Fax: (717) 851-5114	**Gettysburg Hospital** 147 Gettys St. Gettysburg, PA 17325 Phone: (717) 337-4120 Fax: (717) 337-4120	**Ephrata Community Hospital** 169 Martin Avenue Ephrata, PA 17522 Phone: (717) 738-6415 Fax: (717) 738-6533	**Good Samaritan Hospital** 252 S. 4th Street Lebanon, PA 17042 Phone: (717) 270-2299 Fax: (717) 272-4931

Special Handling Instructions

For assistance with special handling of specimens or questions about specimen submission, please contact the appropriate Department of Anatomic Pathology. Information can also be found by accessing the Lab Services website at www.wellspanlabs.org. Thank you for helping to provide exceptional patient care.