

LAB USE ONLY



LABLINK
MEDICAL LABORATORY

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CYTOLOGY REQUISITION FORM

Patient's Name

IC/Passport No.

Clinic/Hospital Reference No.

Date of Birth (dd/mm/yy)

____/____/____

Age

Gender

M F

Race

Malay Chinese Indian Other _____

Address

Specimen Collection Date (dd/mm/yy)

____/____/____

Time (hh/mm)

____/____ AM / PM

Volume of Specimen Submitted: _____ ml

No. of Slides Submitted: _____

Requesting Doctor's Name and Address

Doctor's Signature: _____

URGENT PHONE _____

FAX _____

EMAIL _____

GYNAECOLOGICAL CYTOLOGY

Date of LMP (dd/mm/yy)

____/____/____

Collection Method

Liquid Base (LBC) (61120029 - CyLC1) Conventional/Slide (61120001 - PS1/PS5)

Site

Cervical Combined Endocervical Vaginal Vault

Collection Instrument

Brush Broom Spatula

Cervix

Normal Suspicious Erosion

Contraception

BCP IUD

Clinical Status

Pregnancy (#weeks)_____ Post Partum (#weeks)_____
 Post Menopausal Post Menopausal Bleeding
 Hormone Replacement Therapy

Hysterectomy

Yes No
If Yes :- Total - No Cervix Partial - Cervix Present

Patient History

Biopsy Concurrently Submitted? Yes No

Is Patient Vaccinated for HPV? Yes No

Previous Abnormal Cytology

Result/Date: _____

Biopsy

Result/Date: _____

HPV

HPV/DNA Test HPV/DNA Test (If ASCUS)

NON GYNAECOLOGICAL CYTOLOGY

FINE NEEDLE ASPIRATION CYTOLOGY (FNAC) (61120007)

Breast

Left Right

Thyroid

Left Lobe Right Lobe

Salivary Gland

Left Right Specify Gland: _____

Lymph Node

Site (Specify): _____

OTHER CYTOLOGY (61120003)

Respiratory Tract

Sputum

BAL Site: _____

Bronchial Brushing Site: _____

Body Cavity

Pleural Peritoneal Pericardium Synovial

Urine

Voided Catheterized

Other

Semen
 Other Sites (Specify): _____

CLINICAL HISTORY

