Benefits of providing COMPLETE and LEGIBLE information:

- Reduces turn around time when processing patient samples
- Promotes patient safety through reduced transcription errors

Patient Identification MUST include:

- ✓ First and last name
- ✓ PHN or unique identifier
- ✓ Date of Birth

Saskatchewa
Health Auth

If not a Saskatchewan PHN indicate province

NAME: _____
Last First Middle

HSN: _____ D.O.B.: _____
dd/mmm/yyyy

☐ RUH ☐ SCH ☐ SPH ☐

LABORATORY MEDICINE

HOSPITAL #: _____ STAY #: _____

CERVICAL CYTOLOGICAL (PAP) REQUISITION

ADDRESS: _____
City Province Postal Code

Saskatoon City Hospital
701 Queen Street, Saskatoon SK S7K 0M7
Phone: 306-655-8480 Fax: 306-655-8106

PHONE #: _____

GUARDIAN [if applicable] (PRINTED NAME/SIGNATURE):

In cooperation with **SCREENING PROGRAM FOR CERVICAL CANCER**
A program of the Saskatchewan Cancer Agency

PRINT the physicians name. The name must match the Health Care Providers signature below

Health-care Provider:

Name _____
Last First

Address _____

City/Province _____

Postal code _____

Phone _____ Fax _____

eport To:

_____
First Middle

_____
First Middle

Screening Program for Cervical Cancer
#101-4545 Parliament Avenue
Regina SK S4R 0W3

Collection date must be provided

SPECIMEN: Collection date: _____ _____
dd mmm

☐ Ecto/Endocervix ☐ Vulva

Vaginal: ☐ Pool ☐ Vault ☐ Wall

ECTION TYPE:
onventional PAP
iquid base PAP

SPECIMEN SUBMITTED:
☐ One slide ☐ Two slides
☐ Liquid vial

CLINICAL HISTORY:

LNMP _____ _____ _____
dd mmm yyyy

Menstrual cycle _____

Pregnant (weeks) _____ Gravida # _____

Postpartum (weeks) _____ Parida # _____

☐ Menopause (years) _____

☐ Post-menopause bleeding

Hysterectomy ☐ Total ☐ Subtotal _____ _____
dd mmm

☐ IUD ☐ Oral contraceptive (OPC) _____

☐ HPV Confirmed type _____

HPV vaccine status ☐ Yes ☐ No

☐ Immunocompromised Type _____

EVANT CLINICAL HISTORY:

Clinical History is valuable in the assessment of a pap smear. Please be thorough.

Health-care provider signature

This name must match the printed Health Care Providers above

For Subtotal, indicate if patient still has a cervix

TREATMENT HISTORY:

☐ Cryo Date _____

☐ Hormone therapy Typ

☐ Radiation Date _____

☐ Chemo Type/Date _____ _____ _____
dd mmm yyyy

☐ Laser Date _____ _____ _____
dd mmm yyyy

☐ LEEP Date _____ _____ _____
dd mmm yyyy

☐ Other Date _____ _____ _____
dd mmm yyyy

☐ Colposcopy Date _____ _____ _____
dd mmm yyyy

Previous PAP Date _____ _____ _____
dd mmm yyyy

Lab exam number _____

Lab ex

Failure to supply required information will lead to delays in service

Saskatchewan Health Authority
Department of Pathology and Laboratory Medicine

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