



RUH SCH SPH Other _____

**LABORATORY MEDICINE - CYTOLOGY
CERVICAL CYTOLOGICAL (PAP) REQUISITION**

Saskatoon City Hospital
701 Queen Street, Saskatoon SK S7K 0M7
Phone: 306-655-8389 Fax: 306-655-8399

In cooperation with **SCREENING PROGRAM FOR CERVICAL CANCER**
A program of the Saskatchewan Cancer Agency [1-800-667-0017]

NAME: _____
Last First Middle

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

HOSPITAL #: _____ STAY #: _____

ADDRESS: _____
City Province Postal Code

PHONE #: _____

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

Health-care Provider:

Name _____
Last First Middle

Address _____

City/Province _____

Postal code _____

Phone _____ Fax _____

Copy of Report To:

Name _____
Last First Middle

Name _____
Last First Middle

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

SPECIMEN: Collection date: _____
dd mmm yyyy

Ecto/Endocervix Vulva Time: _____

Vaginal: Pool Vault Wall

COLLECTION TYPE: Conventional PAP Liquid 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 yyyy

IUD Oral contraceptive (OPC) _____

HPV Confirmed type _____

HPV vaccine status Yes No

Immunocompromised Type _____

TREATMENT HISTORY:

Cryo Date _____
dd mmm yyyy

Hormone therapy Type _____

Radiation Date _____
dd mmm yyyy

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 _____

OTHER RELEVANT CLINICAL HISTORY:

Health-care provider signature

LAB USE ONLY:

Lab exam number: _____