VISTA
PATHOLOGY LABORATORY

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Place patient label here

Non-Gynecologic Cytology Requisition

CLIENT INFORMATION

☐ Copy Report to:

Ordering Provider: _____

Name(s): _____

Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____ DOB: _____ ☐ Male ☐ Female

☐ Insurance ☐ Patient ☐ Medicare ☐ OHP ☐ Other: _____

Please attach billing information separately, including patient address, telephone number and insurance information.

SPECIMEN INFORMATION

Collection date: _____

Clinical history/pre-op diagnosis: _____

ICD-9 (required): _____

SPECIMEN SOURCE/SITE

☐ Voided urine
☐ Post-cystology voided urine
☐ Loop urine
☐ Bladder wash
☐ Ureter wash: ☐ L ☐ R
☐ Renal pelvis: ☐ L ☐ R

Urinary tract specimens:
- ☐ Cytology only
- ☐ Cytology + FISH
- ☐ Reflex to FISH if suspicious for high-grade lesion

☐ CSF:
- ☐ r/o inflammatory process
- ☐ r/o neoplasm

☐ Sputum
☐ Nipple discharge ☐ L ☐ R
☐ Tzanck prep
☐ Thyroid FNA: ☐ L ☐ R ☐ isthmus
☐ Non-thyroid FNA, specific site(s), e.g., parotid, lymph node, etc: _____
☐ Other cytology _____