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-10 (required): _____

SPECIMEN SOURCE/SITE

- ☐ Voided urine
- ☐ Post-cystoscopy voided urine
- ☐ Loop urine
- ☐ Bladder wash
- ☐ Ureter wash: ☐ L ☐ R
- ☐ Renal pelvis: ☐ L ☐ R
- ☐ CSF:
  - ☐ r/o inflammatory process
  - ☐ r/o neoplasm
- ☐ Sputum
- ☐ Nipple discharge ☐ L ☐ R
- ☐ Tzanck prep
- ☐ Thyroid FNA: ☐ L ☐ R ☐ isthmus
  - ☐ Reflex to molecular testing for suspicious or atypical cases (thyroid FNAs only)
- ☐ Non-thyroid FNA, specific site(s),
  e.g., parotid, lymph node, etc: _____
- ☐ Other cytology _____