



# SURGICAL PATHOLOGY AND CYTOLOGY REQUISITION

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Patient Demographics			Ordering Physician Information		
PATIENT NAME (Last)	(First)	(MI)	NAME & CREDENTIALS (Printed)		
DATE OF BIRTH	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PHYSICIAN SIGNATURE		
ADDRESS					
CITY	STATE	ZIP	PRACTICE NAME AND ADDRESS	PHONE:	
HOME PHONE	SOCIAL SECURITY #				
Clinical History / Diagnosis / Operative Findings			COPY RESULTS TO:		
			Insurance Details (Please attach copy of insurance card, front & back)		
			ICD-10 (Required) 1. _____ 2. _____ 3. _____		
			Collection Information		
			COLLECTOR: _____	DATE: ____/____/____	TIME: _____

## SURGICAL PATHOLOGY TISSUE SPECIMENS (Additional Specimen IDs on back)

Specimen ID	Specimen Site / Description	Procedure	Removal Time	Time into Formalin
A				
B				
C				
D				
E				
F				

## GYN CYTOLOGY (PAP TEST)

Last Menstrual Period (LMP): \_\_\_\_/\_\_\_\_/\_\_\_\_ SOURCE:  CERVIX  VAGINA  Other: \_\_\_\_\_

Test Requested (select one):	Current Clinical Findings:	Previous Abnormal Findings:
<input type="checkbox"/> Pap Only <input type="checkbox"/> Pap + HPV (Any Diagnosis) <input type="checkbox"/> Pap + HPV (Reflex if ASC-US) <input type="checkbox"/> HPV Only	<input type="checkbox"/> Abnormal or Postmenopausal Bleeding <input type="checkbox"/> Breastfeeding <input type="checkbox"/> BCPs / Depo Provera <input type="checkbox"/> Estrogen / Hormonal Therapy <input type="checkbox"/> IUD <input type="checkbox"/> Patient's First Pap <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Post Partum <input type="checkbox"/> Pregnant <input type="checkbox"/> Radiation / Chemotherapy <input type="checkbox"/> Supracervical Hysterectomy <input type="checkbox"/> Total Hysterectomy <input type="checkbox"/> Visible Lesion on Pelvic Exam	<input type="checkbox"/> Last Pap - ASC-US/HPV+ <input type="checkbox"/> Previous ASC-H (past 5 years) <input type="checkbox"/> Previous Atypical Glandular Cells <input type="checkbox"/> Previous Cancer (Cervical) <input type="checkbox"/> Previous Cancer (Ovarian) <input type="checkbox"/> Previous Cancer (Uterine/Endometrial) <input type="checkbox"/> Previous HPV Genotype 16 or 18/45+ <input type="checkbox"/> Previous HPV+ (past 5 years) <input type="checkbox"/> Previous HSIL <input type="checkbox"/> Previous LSIL (past 5 years) <input type="checkbox"/> Other: _____
<b>Additional Tests Available:</b> <input type="checkbox"/> Chlamydia and Gonorrhea Screen <input type="checkbox"/> Trichomonas Screen		

## NON-GYN CYTOLOGY

URINE SOURCE:  Voided  Catheterized  Cystoscopic  Bladder  Kidney, Right  Kidney, Left  Other: \_\_\_\_\_

Abscess  Body Fluid  Bronchial Lavage  Brush  CSF  Cyst  Fine Needle Aspirate (FNA)  Smear/Scrape  Sputum  Wash

SOURCE: \_\_\_\_\_  Right  Left Air-Dried Slides # \_\_\_\_\_ Fixed Slides # \_\_\_\_\_

Lab Use: Volume Received: \_\_\_\_\_ Specimen Description upon receipt: \_\_\_\_\_



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## ADDITIONAL SURGICAL SPECIMEN INFORMATION

Specimen ID	Specimen Site / Description	Procedure	Removal Time	Time into Formalin
G				
H				
I				
J				
K				
L				
M				
N				
O				
P				
Q				
R				

## SURGICAL SPECIMEN REQUIREMENTS

✳ **Specimen Containers:**

- If more than one container, each container must be recorded sequentially and lettered.
- Each container must contain 2 patient identifiers.
- For adequate fixation, formalin volume should be at least 10 times specimen size.

✳ **Clinical History and Operative Findings:**

- Provide the appropriate ICD code for testing.
- Provide any relevant history and clinical information for optimal diagnostic interpretation and insurance/billing.

✳ **Removal Time / Time into Formalin:**

- **ALL routine surgical specimens should be submitted in 10% buffered formalin.**
- Removal time - the time the specimen was surgically removed from the patient.
- Time into formalin - the time the specimen was placed into 10% buffered formalin.
- Specimens should be placed into formalin within 60 minutes of removal.

## WELLSPAN PATHOLOGY LABORATORY LOCATIONS

YORK	ADAMS	LANCASTER	LEBANON
<b>York Hospital</b> 1001 South George St. York, PA 17403 Phone: (717) 851-5001 Fax: (717) 851-5114	<b>Gettysburg Hospital</b> 147 Gettys St. Gettysburg, PA 17325 Phone: (717) 337-4120 Fax: (717) 337-4120	<b>Ephrata Community Hospital</b> 169 Martin Avenue Ephrata, PA 17522 Phone: (717) 738-6415 Fax: (717) 738-6533	<b>Good Samaritan Hospital</b> 252 S. 4th Street Lebanon, PA 17042 Phone: (717) 270-2299 Fax: (717) 272-4931
FRANKLIN	FRANKLIN	Special Handling Instructions	
<b>Chambersburg Hospital</b> 112 N. 7th St. Chambersburg, PA 17201 Phone: (717) 267-7153 Fax: (717) 267-7127	<b>Waynesboro Hospital</b> 501 E. Main St. Waynesboro, PA 17268 Phone: (717) 765-3403 Fax: (717) 765-3415	<i>For assistance with special handling of specimens or questions about specimen submission, please contact the appropriate Department of Anatomic Pathology. Information can also be found by accessing the Lab Services website at <a href="http://www.wellspanlabs.org">www.wellspanlabs.org</a>. Thank you for helping to provide exceptional patient care.</i>	