

MED-HEALTH LABORATORIES LTD.

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DATE RECEIVED: **CYTOLOGY** REF. LAB. NO.: Liquid Base Specimen: Label vial with patient's first and last name. Conventional smear: Please mark patient's name on frosted end slide using lead pencil, before smear is taken. NO. OF SLIDES: Immediate fixation of still wet smear imperative. OHIP No. PATIENT'S LAST NAME: V.C. FIRST NAME PATIENT'S DATE OF BIRTH SEX ΝО □ HAS PATIENT HAD PAP TEST DONE WITHIN LAST 3 YEARS YES \square YFAR MONTH DAY PATIENT OHIP PT. CASH PT. IFH RMB **PROVINCE** PATIENT'S ADDRESS: PT HOME TEL: CELL PHONE: DOCTOR'S NAME: PHYSICIAN NO.: TELEPHONE: FAX NUMBER: ADDRESS: TYPE OF SPECIMEN: VAGINAL □ CERVICAL □ COMBINED □ OTHER \square CLINICAL DATA (IMPORTANT): PREVIOUS CYTOLOGY DATE: NO: DATE SMEAR TAKEN: CLINICAL DIAGNOSIS AND REMARKS LMP: (FIRST DAY): MENOPAUSE: HORMONE THERAPY: PHYSICIAN'S SIGNATURE PARITY:

CYTO NUMBER: