



Unilabs

IHS

The Cromwell Hospital
Cytology



Accredited Medical
Laboratory
Reference No. 2380

P L E A S E P R I N T C L E A R L Y

Room No. or Dept	Patient's Surname														
Nature of Specimens	Title and Other Names														
	Date of Birth	/Sex													
	Hospital No.														
	Consultant's Name(s)														
Clinical Details	Date														
	<p>GYNAECOLOGICAL CYTOLOGY</p> <p>GOLD STANDARD</p> <p><input type="checkbox"/> THIN PREP™ PAP, HIGH RISK HPV CHLAMYDIA COMBINATION</p> <p><input type="checkbox"/> THIN PREP™ PAP HIGH RISK HPV COMBINATION</p> <p>LMP_____ Last Smear Test_____</p> <p><input type="checkbox"/> Menopause <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Irregular Bleeding</p> <p><input type="checkbox"/> Post Menopause <input type="checkbox"/> IUCD <input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Pregnant <input type="checkbox"/> HRT <input type="checkbox"/> Erosion/Cervicitis</p> <p><input type="checkbox"/> Post Natal <input type="checkbox"/> O/C <input type="checkbox"/> Suspicious Cervix</p> <p>NB: PMI rates will apply unless otherwise stated.</p>	<p style="text-align: center;">LABORATORY USE ONLY</p> <table border="1"> <tr><td>A.</td><td></td></tr> <tr><td>B.</td><td></td></tr> <tr><td>C.</td><td></td></tr> <tr><td>D.</td><td></td></tr> <tr><td>E.</td><td></td></tr> <tr><td>F.</td><td></td></tr> <tr><td>G.</td><td></td></tr> </table>	A.		B.		C.		D.		E.		F.		G.
A.															
B.															
C.															
D.															
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F.															
G.															
Previous Histology/Cytology No. (if relevant)	Date/Time of specimen														
Consultant's Signature	OTHERS: ENTER CODE														