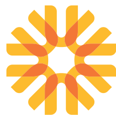

Unilabs
IHS

# The Hospital of St John and St Elizabeth
# Cytology

Accredited Medical Laboratory
Reference No. 2380

PLEASE PRINT CLEARLY

Room No. or Dept

Nature of Specimens

Patient's Surname

Title and Other Names

Date of Birth

Hospital No.

Consultant's Name(s)

Date/Time of Specimen

Sex

Clinical Details

Previous Histology/Cytology No. (if relevant)

## GYNAECOLOGICAL CYTOLOGY

**GOLD STANDARD**

- ☐ THIN PREP™ PAP, HIGH RISK HPV CHLAMYDIA COMBINATION
- ☐ THIN PREP™ PAP HIGH RISK HPV COMBINATION
- ☐ CHLAMYDIA (THIN PREP™)
- ☐ THIN PREP™ PAP
- ☐ HIGH RISK HPV
- ☐ GONORRHEA (THIN PREP™)

LMP__________ Last Smear Test__________

- ☐ Menopause
- ☐ Post Menopause
- ☐ Pregnant
- ☐ Post Natal
- ☐ Hysterectomy
- ☐ IUCD
- ☐ HRT
- ☐ O/C
- ☐ Irregular Bleeding
- ☐ Discharge
- ☐ Erosion/Cervicitis
- ☐ Suspicious Cervix

☐ Digital Pathology Image (please tick)

Invoice to Dr ☐ Patient ☐

Address for Invoice

Consultant's Signature

Date