



Unilabs

IHS

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.	
Clinical Details	Consultant's Name(s)	
	Date and Time of Specimen	
	<p>GYNAECOLOGICAL CYTOLOGY</p> <p>THINPREP™ (TP) VIAL</p> <p><input type="checkbox"/> Gold Standard TP™ PAP, cobas® HPV*, cobas® Chlamydia</p> <p><input type="checkbox"/> TP™ PAP, cobas® HPV* COMBINATION</p> <p><input type="checkbox"/> HPV FULL SUBTYPING</p> <p><input type="checkbox"/> TP™ PAP</p> <p><input type="checkbox"/> cobas® HPV*</p> <p>*High risk panel plus 16 & 18 genotyping</p> <p>LMP _____ Last Smear Test _____</p>	<p>Please tick appropriate box to ensure required billing procedure</p> <p>Invoice to Insurer <input type="checkbox"/> Dr <input type="checkbox"/> Patient <input type="checkbox"/></p> <p>Insurance Details (PMI)</p>
	<p><input type="checkbox"/> Menopause <input type="checkbox"/> Post Natal <input type="checkbox"/> Irregular Bleeding</p> <p><input type="checkbox"/> Post Menopause <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Pregnant <input type="checkbox"/> IUCD <input type="checkbox"/> Erosion/Cervicitis</p> <p><input type="checkbox"/> HRT <input type="checkbox"/> O/C <input type="checkbox"/> Suspicious Cervix</p>	Address for Invoice (Patient)
Consultant's Signature		