



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 and Time of Specimen _____																											
	<p>GYNAECOLOGICAL CYTOLOGY THINPREP™ (TP) VIAL</p> <table border="0"> <tr> <td><input type="checkbox"/> Gold Standard TP™ PAP, cobas® HPV*, cobas® Chlamydia</td> <td><input type="checkbox"/> HPV FULL SUBTYPING</td> <td><input type="checkbox"/> CHLAMYDIA</td> </tr> <tr> <td><input type="checkbox"/> TP™ PAP, cobas® HPV* COMBINATION</td> <td><input type="checkbox"/> TP™ PAP</td> <td><input type="checkbox"/> GONORRHOEA</td> </tr> <tr> <td></td> <td><input type="checkbox"/> cobas® HPV*</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> cobas® CHLAMYDIA</td> <td><input type="checkbox"/> CHLAMYDIA</td> </tr> <tr> <td></td> <td><input type="checkbox"/> GONORRHOEA</td> <td><input type="checkbox"/> GONORRHOEA</td> </tr> </table> <p>LMP _____ Last Smear Test _____ *High risk panel plus 16 & 18 genotyping</p> <table border="0"> <tr> <td><input type="checkbox"/> Menopause</td> <td><input type="checkbox"/> HRT</td> <td><input type="checkbox"/> IUCD</td> <td><input type="checkbox"/> Discharge</td> </tr> <tr> <td><input type="checkbox"/> Post Menopause</td> <td><input type="checkbox"/> Post Natal</td> <td><input type="checkbox"/> O/C</td> <td><input type="checkbox"/> Erosion/Cervicitis</td> </tr> <tr> <td><input type="checkbox"/> Pregnant</td> <td><input type="checkbox"/> Hysterectomy</td> <td><input type="checkbox"/> Irregular Bleeding</td> <td><input type="checkbox"/> Suspicious Cervix</td> </tr> </table>	<input type="checkbox"/> Gold Standard TP™ PAP, cobas® HPV*, cobas® Chlamydia	<input type="checkbox"/> HPV FULL SUBTYPING	<input type="checkbox"/> CHLAMYDIA	<input type="checkbox"/> TP™ PAP, cobas® HPV* COMBINATION	<input type="checkbox"/> TP™ PAP	<input type="checkbox"/> GONORRHOEA		<input type="checkbox"/> cobas® HPV*			<input type="checkbox"/> cobas® CHLAMYDIA	<input type="checkbox"/> CHLAMYDIA		<input type="checkbox"/> GONORRHOEA	<input type="checkbox"/> GONORRHOEA	<input type="checkbox"/> Menopause	<input type="checkbox"/> HRT	<input type="checkbox"/> IUCD	<input type="checkbox"/> Discharge	<input type="checkbox"/> Post Menopause	<input type="checkbox"/> Post Natal	<input type="checkbox"/> O/C	<input type="checkbox"/> Erosion/Cervicitis	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Irregular Bleeding	<input type="checkbox"/> Suspicious Cervix
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