



Unilabs

IHS

Prof. Stuart Stanton
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 <input type="checkbox"/> 360 degree sweep (please tick) <input type="checkbox"/> Cervix visualised (please tick) <input type="checkbox"/> Digital Pathology Image (please tick) Previous Histology/Cytology No. (if relevant)	Date and Time of Specimen				
	GYNAECOLOGICAL CYTOLOGY THINPREP™ (TP) VIAL <input type="checkbox"/> Gold Standard TP™ PAP, cobas® HPV*, cobas® Chlamydia <input type="checkbox"/> TP™ PAP, cobas® HPV* COMBINATION <input type="checkbox"/> HPV FULL SUBTYPING <input type="checkbox"/> TP™ PAP <input type="checkbox"/> cobas® HPV* *High risk panel plus 16 & 18 genotyping LMP _____ Last Smear Test _____	Please tick appropriate box to ensure required billing procedure <table border="1" data-bbox="1102 611 1544 667"> <tr> <td data-bbox="1102 611 1321 667">Invoice to Insurer <input type="checkbox"/></td> <td data-bbox="1321 611 1417 667">Dr <input type="checkbox"/></td> <td data-bbox="1417 611 1544 667">Patient <input type="checkbox"/></td> </tr> </table> Insurance Details (PMI) Address for Invoice (Patient)	Invoice to Insurer <input type="checkbox"/>	Dr <input type="checkbox"/>	Patient <input type="checkbox"/>
	Invoice to Insurer <input type="checkbox"/>	Dr <input type="checkbox"/>	Patient <input type="checkbox"/>		
<input type="checkbox"/> Menopause <input type="checkbox"/> Post Menopause <input type="checkbox"/> Pregnant <input type="checkbox"/> HRT <input type="checkbox"/> Post Natal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> IUCD <input type="checkbox"/> O/C <input type="checkbox"/> Irregular Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Erosion/Cervicitis <input type="checkbox"/> Suspicious Cervix					
Consultant's Signature					