



Please send sample to 43a Wimpole Street W1G 8AQ Tel: 020 7486 5091

HOSPITAL (please tick) Harley Street Clinic <input type="checkbox"/> Lister Hospital <input type="checkbox"/> London Bridge Hospital <input type="checkbox"/> Portland Hospital <input type="checkbox"/> Princess Grace Hospital <input type="checkbox"/> Wellington Hospital <input type="checkbox"/> Location: _____	CONSULTANT'S NAME: Secretary's Number: Copy to: _____ Address: _____ _____ _____ Postcode: _____
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PATIENT DETAILS Surname: _____ Patient First Name(s): _____ Date of Birth: _____ Age: _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Hospital Number (X number): <u> X </u> _____ NB - Samples will NOT be processed without ALL the above information Current Account Number: _____	CLINICAL DETAILS
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NON GYNAECOLOGICAL CYTOLOGY Sample Type <input type="checkbox"/> Hot FNA (by appointment on 0207 299 4494) <input type="checkbox"/> Flow Cytometry <input type="checkbox"/> Digital Image Please enclose Red Card with request if urgent	GYNAECOLOGICAL CYTOLOGY THINPREP™ (TP) VIAL <input type="checkbox"/> Gold Standard TP™ PAP, cobas® HPV*, cobas® Chlamydia <input type="checkbox"/> TP™ HPV FULL SUBTYPING <input type="checkbox"/> TP™ PAP <input type="checkbox"/> TP™ cobas® HPV* <small>*High risk panel plus 16 & 18 genotyping</small> <input type="checkbox"/> TP™ PAP, cobas® HPV* COMBINATION <input type="checkbox"/> TP™ cobas® CHLAMYDIA <input type="checkbox"/> TP™ GONORRHOEA LMP: _____ Last Smear Test: _____ <input type="checkbox"/> Menopause <input type="checkbox"/> Post Menopause <input type="checkbox"/> Pregnant <input type="checkbox"/> Post Natal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> IUCD <input type="checkbox"/> HRT <input type="checkbox"/> O/C <input type="checkbox"/> Irregular Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Erosion/Cervicitis <input type="checkbox"/> Suspicious Cervix	NON GYNAECOLOGICAL CYTOLOGY <input type="checkbox"/> Urine <input type="checkbox"/> Fluid <input type="checkbox"/> FNA <input type="checkbox"/> Other
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Date and Time of Specimen: _____	Signature: _____
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