



**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  <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)	Consultant's Name(s)		
	Date and Time of Specimen		
	<b>GYNAECOLOGICAL CYTOLOGY</b> 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 _____	<input type="checkbox"/> cobas® CHLAMYDIA <input type="checkbox"/> GONORRHOEA <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> GONORRHOEA <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> GONORRHOEA	Please tick appropriate box to ensure required billing procedure Invoice to Insurer <input type="checkbox"/> Dr <input type="checkbox"/> Patient <input type="checkbox"/> Insurance Details (PMI)
	<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	Address for Invoice (Patient)	
Consultant's Signature			