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**CYTOPATHOLOGY REQUISITION FORM**

Corporate \_\_\_\_\_ Referring Doctor \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: Male / Female  
Telephone \_\_\_\_\_ Collection Centre \_\_\_\_\_ RCC \_\_\_\_\_  
(If different)

**GYNAE CYTOLOGY:**

- Conventional Pap smear  
 Thin Prep

**CLINICAL FEATURES:**

- Normal  Post-Menopausal  
 Suspicious Lesions  Others

**SITE OF SAMPLE:**

- Cervix  Endocervix  Post fornix  
 Lat. Vaginal Wall  Vault  Others

**HISTORY:**

- Post-Menopausal  
 Hormone Replacement (HRT)  
 Others

LMP : \_\_\_ / \_\_\_ / \_\_\_

**NONGYNAE CYTOLOGY:**

- Ascitic / Peritoneal  
 Pleural  
 CSF  
 Urine  
 Pericardial  
 Bronchial  
 Sputum  
 Others

**NIPPLE DISCHARGE:**

- Right  
 Left  
 Both

**FNAC**

**A. THYROID:**

Site : .....

Size : .....

Duration : .....

Consistency: .....

Nodule : Solitary nodule : ..... Multiple nodules ... .....

Margins : Well defined : ..... Not clearly made out : .....

Associated lymph nodes : Yes / No.

USG / Serology / Hormonal assay :

**B. BREAST:**

Site : .....

Size : .....

Duration : .....

Swelling : Fixed / Mobile

Associated axillary lymph nodes : Yes / No

USG / Mammography findings: .....

**OTHERS / MISCELLANEOUS:** .....  
.....

**RELEVANT DETAILS:** .....  
.....

**INSTRUCTIONS FOR FILLING UP FORM:**

1. Please tick appropriate boxes only as
2. Please furnish complete clinical details along with Request form.
3. Samples details not covered above should be entered in Miscellaneous box.
4. Do not omit telephone number of Patient / Referring Doctor.