Edward-Elmhurst HEALTH | Healthy Driven

Cytology/Body Fluids Requisition

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Client Demographics	Patient Information/ Label
	Name:
	Medical Record Number:
	DOB: Age:
	Billing number:

Requisition prepared by:________________________________ Date of Service: _____________ Time of Procedure:____________

Location: ____

CLIENT INFORMATION

Submitting Physician: __________________________________ Primary Physician: ____

Additional Physician with Fax number: ____

CLINICAL INFORMATION

Pre-Operative Diagnosis/ Clinical History: ____

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Biopsy Performed at the same time ☐ Submit Surgical Pathology Requisition also.

SPECIMEN(S) SUBMITTED

FLUIDS

____ Cerebrospinal fluid
____ Pleural (Thoracentesis) Left __ Right __
____ Peritoneal (Ascites/Paracentesis)
____ Pericardial
____ Abd/Pelvic washings Site #1 Left __ Right __
____ Abd/Pelvic washings Site #2 Left __ Right __
____ Other:_________________________

URINE

____ Voided
____ Catheterized
____ Ureter washing Site #1 Left __ Right __
____ Ureter washing Site #2 Left __ Right __
____ Renal pelvic washings Site #1 Left __ Right __
____ Renal pelvic washings Site #2 Left __ Right __
____ Bladder Washings

BRONCHIAL

Washing	Site #1 ___________________________	Site #2 ___________________________
Brushing	Site #1 ___________________________	Site #2 ___________________________
Lavage	Site #1 ___________________________	Site #2 ___________________________
Needle Aspiration	Site #1 ___________________________	Site #2 ___________________________
Sputum	Site #1 ___________________________	Site #2 ___________________________
Other (specify)	Site #1 ___________________________	Site #2 ___________________________

GASTROINTESTINAL

____ Esophageal brushing (Rule out Candida)
____ Bile duct brushing
____ Other (specify) ________________________

BREAST

____ Breast cyst fluid Left __ Right __
____ Other (specify) ____________________________

ANCILLARY STUDIES

RPMI for lymphoma/leukemia studies:
Special Stains ☐ AFB ☐ Fungal ☐ Pneumocystis ☐ Other ___________________

LAB USE ONLY____ Cell Block: Yes ☐ No ☐

For any patient of any payer, only order those test which are medically reasonable and necessary for the diagnosis and treatment of the patient as defined by Medicare. Some tests have diagnosis and/or frequency limitations and may not be covered.