



PORT HURON

1221 Pine Grove, Port Huron, MI 48060

Path No.

Patient Identification

Specimens Received
No. Containers:
Slides: Swab:
Other:
Received in Lab
Date
Time
Initials

Surgical/Cytology Request Form

Date Collected: Time Initials: Ordering Physician:

Comment: Copies To:

CLINICAL HISTORY/DIAGNOSIS/OPERATIVE/ENDOSCOPIC FINDINGS
OB/GYN CLINICAL HISTORY
LNMP
HIGH RISK HPV
ASCUS AGUS
LSIL HSIL
ABNORMAL BLEEDING
BCP HORMONAL THERAPY
HYSTERECTOMY
PMB POSTPARTUM PREGNANT
RADIATION
OTHER

PROCEDURE
KNOWN MALIGNANCY NO YES

SURGICAL SPECIMENS (SITE)
CYTOLOGY SPECIMENS (SITE)
ADDITIONAL REQUESTS ON SURGICALCYTOLOGY SPECIMENS ONLY
LAB TESTS ON BODY FLUIDS ONLY
CELL COUNT
AMYLASE
CHOLESTEROL
GLUCOSE
LDH
PROTEIN
OTHER
MICROBIOLOGY ORDERS (TISSUE SHOULD BE SUBMITTED SEPARATE FROM SURGICAL SPECIMEN IN STERILE CONTAINER.)
SPECIMEN SOURCE:
AEROBIC CULTURE + GRAM STAIN
AEROBIC/ANAEROBIC CULTURE +GRAM STAIN
TB CULTURE + AFB SMEAR
FUNGAL CULTURE
VIRUS, COMPREHENSIVE DETECTION
OTHER

STILLBORN FETUS: (LESS THAN 20 WEEKS OR 400 GRAMS)
EXTERNAL GROSS EXAMINATION ONLY UNLESS BOX BELOW CHECKED AND SIGNED
DISSECTION/MICROSCOPIC EXAMINATION: Physician/Nurse Signature Date / Time

LAB USE ONLY FOR INTRAOPERATIVE CONSULTATION:

I, the undersigned pathologist, have confirmed the patient's identification and verbally delivered the report to the submitting clinician.
Signature of Pathologist Date / Time

