

Place addressograph here where available:

Surname: \_\_\_\_\_  
Forename: \_\_\_\_\_  
DOB / SEX: \_\_\_\_\_ / \_\_\_\_\_  
Hospital Number: \_\_\_\_\_  
Consultant Name: \_\_\_\_\_

**Private Patient**

**NHS Patient**

- Inpatient - IP
- Outpatient - OPD
- Day Case - DCU
- MPU
- Endoscopy
- X-Ray

**UKAS Ref #: 9685**

Laboratory Use Only

**CLINICAL DETAILS FOR EACH SPECIMEN**

**Urgent Case,  
Result Required**  
BY: \_\_\_\_\_ / \_\_\_\_\_

**Gynaecology Test Ordering**

- Cervical Smear** (Thin-Prep Hologic Liquid Based Cytology LBC)
- Additional testing from the Hologic Thin-Prep vial**
- HPV** (Routine Human Papilloma Virus Testing)
- HPV20** (20 HPV DNA Subtypes)
- HPVT** (HPV20 with reflex mRNA for E6/E7 oncotype)
- TPCR** (Chlamydia PCR)
- TGON** (Gonorrhoea PCR)
- TCG** (Chlamydia & Gonorrhoea PCR)
- 7STD** (7 microorganisms from PCR, Chlamydia, Gonorrhoea, Mycoplasma, Ureaplasma, Gardnella, Trichomonas, Herpes HSV I&II)
- Other Gynae Associated Testing**
- HVS** (High Vaginal Swab)
- Other** (state requirements)

**Gynaecology Clinical Information**

**LMP** (Last Menstrual Period) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Last Cervical Smear** (date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Place of last Cervical Smear** \_\_\_\_\_

**Last Cervical Smear Case Number** \_\_\_\_\_

**Previous Abnormal History?** \_\_\_\_\_

**Previous HPV Testing Result** \_\_\_\_\_

**Additional Details for Gynae Specimens**

- Perimenopausal
- Postmenopausal
- Hysterectomy
- IUCD
- Irregular Bleeding
- Discharge
- Pregnant
- HRT
- Post-Natal
- Erosion/Cervicitis
- Oral Contraceptives
- Suspicious Cervix

**SPECIMEN DETAILS (Multiples use A, B, C...)**

Gross photo

Microscopic photo

Please tick if the patient does **NOT** agree for slides/blocks to be sent to other histopathologists when it is clinically necessary. If consent to send slides/blocks is not given by the patient (i.e box is not ticked) it must be understood that this may compromise patient's care.

Consultant Signature \_\_\_\_\_ Sample Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sample Time \_\_\_\_\_ :

**Invoice To:**

- Hospital     Doctor     Patient

Insurance

Insurance Company: \_\_\_\_\_

Membership Number: \_\_\_\_\_

Authorisation Number: \_\_\_\_\_

**Histology & Cytology Medical Laboratory Testing**

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Dwight Road, Tolpits Lane,  
Watford, Hertfordshire, WD18 9DA

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Email: [info@cellpathservices.co.uk](mailto:info@cellpathservices.co.uk)  
[www.cellularpathologyservices.co.uk](http://www.cellularpathologyservices.co.uk)

UKAS Ref #: 9685  
CQC Registered ID: 1-240465912

**Useful Information**

**Contact us: 01923 233299**

**Out of hours: 07775 44 66 88**

Call the Office Team for Specimen collection, results, consumables and administrative enquiries.

Opening hours 9.00am - 6.00pm.

Clinical and out of hours enquiries please contact us at anytime - Call Dr J El-Jabbour on 07879637874 or Dr P Mitra on 07711655294

**Out of hours:** For all out of hours enquiries regarding results, courier and consumables call **07775 44 66 88**

Our online e-PathSys results service is available 24/7 via [www.cellularpathologyservices.co.uk](http://www.cellularpathologyservices.co.uk). For further details contact us.

Cellular Pathology Services use only below this line:

Laboratory Use:					Pathologist Use:				Charges:				
BI	MAC	MIC	DISP	EM	Path 1	Path 2	BCC	Non BCC	Charge ID	Charge Description	Code	Qty	Initials
									1				
Approved by:					Date:				2				
									3				