

CYTOLOGY & HISTOPATHOLOGY (F026)

世圖 婦科細胞化驗中心有限公司
CytoLab Pap Test Screening Centre Ltd.
 28/F Lee & Man Commercial Center, 169 Electric Rd., Fortress Hill, HK
 香港炮台山電氣道169號理文商業中心28樓
Specimen Pick Up:
 Central : 3651 1200 HK Island : 3983 1800
 Causeway Bay : 3651 1100 Kowloon : 3651 1000



ST. TERESA'S HOSPITAL
聖德肋撒醫院
Histopathology Laboratory
 組織病理化驗室
Specialists in Pathology *FHKAM (Pathology)*
 Dr. KAN Chi Hang Dr. FUNG Shing Hoi
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LAB USE ONLY

LAB No.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

2 PATIENT IDENTIFIERS ARE REQUIRED

| | | | | | | |
|---------------------|--------------------|---|--|---|--|---|
| Family name 姓 _____ | Given name 名 _____ | <input type="checkbox"/> HKID <input type="checkbox"/> 2 Way | <input type="checkbox"/> Passport <input type="checkbox"/> Others | D.O.B. 出生日期 ____/____/____ dd mm yyyy | <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女 | Date collected _____ Time _____ <input type="checkbox"/>am <input type="checkbox"/>pm |
| Referred by _____ | | | | | <input type="checkbox"/> Payment in Lab (otherwise on account) | |

Clinical details Fasting Non-fasting Routine screen Pregnant wks Others: _____
 Pre-examination requirement checked by: _____

Doctor's instructions

FOR MANAGED CARE PATIENTS ONLY - PLEASE FILL IN

| | | | |
|-----------------------|-------------------|---|--------------------------------|
| Organization _____ | Diagnosis _____ | | |
| Member card no. _____ | Expiry date _____ | <input type="checkbox"/> Voucher attached | Doctor's Signature: _____ |
| | | <input type="checkbox"/> No Voucher | Card Holder's Signature: _____ |

GYNAE CYTOLOGY

| | | |
|---|---|---|
| <input type="checkbox"/> SurePath Pap [H106A] <input type="checkbox"/> Conventional Pap Smear [H086] | Previous lab no. (If any) _____ LMP: Day _____ Month _____ Year _____ | FOR LAB USE ONLY A. Prev Lab: _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ Primary Screen Rescreen Check 1 (Tech) Check 2 (IC) |
| <input type="checkbox"/> Monolayer Pap + HPV Genotypes [CY01] <input type="checkbox"/> Monolayer Pap + HPV Genotypes [CY02] + Chlamydia DNA <input type="checkbox"/> Monolayer Pap + HPV Genotypes [CY03] + Chlamydia DNA + Gonococcus DNA <input type="checkbox"/> HPV Genotypes [R076] <input type="checkbox"/> Chlamydia DNA [R035] <input type="checkbox"/> Gonococcus DNA [R017] <input type="checkbox"/> Chlamydia DNA + Gonococcus DNA [IN10] <input type="checkbox"/> Others _____ | <input type="checkbox"/> Cervical Appearance <input type="checkbox"/> Healthy <input type="checkbox"/> Erosion <input type="checkbox"/> Polyp <input type="checkbox"/> Tumour <input type="checkbox"/> Others _____ <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> IUCD In-situ <input type="checkbox"/> On hormonal therapy <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Pregnant _____ weeks <input type="checkbox"/> Post-Partum _____ weeks <input type="checkbox"/> Menopausal _____ years <input type="checkbox"/> Other relevant history (If any) _____ | |

For Plus tests, TAT may be slightly faster if additional VTM is taken.

HISTOPATHOLOGY AND NON-GYNAE CYTOLOGY

| | | |
|---|---|--|
| <input type="checkbox"/> Tissue Biopsy [H087] Specimen(s) _____ Surgical procedure: _____ | Previous lab no. (If any) _____ Clinical summary / diagnosis _____ | PATH NO. _____ Specimens Received: <input type="checkbox"/> SurePath Vial <input type="checkbox"/> Conv. Pap Smear <input type="checkbox"/> VTM <input type="checkbox"/> Tissue in Formalin <input type="checkbox"/> FNA Rinsing Fluid <input type="checkbox"/> Sputum <input type="checkbox"/> Urine <input type="checkbox"/> Others _____ Checked By _____ |
| <input type="checkbox"/> FNA cytology [H112] Site(s) _____ | | |
| <input type="checkbox"/> Body fluid cytology [H088] Specimen(s) _____ | | |