

# **CYTOPATHOLOGY REQUEST**

## **FORM**

FNAC ☐

FLUID CYTOLOGY ☐

REFERRING HEALTH INSTITUTION: \_\_\_\_\_ DATE:  
\_\_\_\_\_

### **PATIENT IDENTIFICATION**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ MRN:  
\_\_\_\_\_

PHONE NO: \_\_\_\_\_ E-MAIL:  
\_\_\_\_\_

REQUESTING PHYSICIAN: \_\_\_\_\_ PHONE:  
\_\_\_\_\_

EMAIL: \_\_\_\_\_

REQUESTING DEPARTMENT:  
\_\_\_\_\_

SITE OF ASPIRATION:  
\_\_\_\_\_

RELEVANT CLINICAL DATA:  
\_\_\_\_\_  
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\_\_\_\_\_  
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RELEVANT LAB DATA & RADIOLOGIC FINDING:  
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**N.B: Kindly note that requests without complete demographic data and adequate relevant clinical data will be rejected.**