Reg No 198904227G

KK Women's and Children's Hospital
SingHealth

NON-GYNAECOLOGICAL CYTOLOGY

Patient's name label

(For Downtime Use)
Name:
MRN:
Account Number:
Date of Birth:
Sex: M / F (Circle one)

Department/Speciality: _____

Ward/Bed: _____ **Clinic:** _____ **Class:** _____

Patient Type ☐ Gynae ☐ Obst ☐ Neo ☐ Paed Medicine ☐ Paed Surgery

PATIENT'S HISTORY

Clinical History/Operative Findings

Cytology No.:

Clinical Diagnosis:

Previous Biopsy No(s) and Results:

NATURE OF SPECIMEN Please tick (√) appropriate box(es)

- ☐ Peritoneal (Ascitic) Fluid
- ☐ Pertioneal washings
- ☐ Pleural Fluid
  - ☐ Right
  - ☐ Left
- ☐ BAL
- ☐ CSF
- ☐ Cyst Fluid (specify site)

  _____
- ☐ Urine
  - ☐ Voided
  - ☐ Catheter
- ☐ Others (specify site)

  _____
- ☐ Fine Needle Aspiration
  (specify site/source)

  _____
- ☐ Special instruction/request

  _____

COLLECTION DETAILS

Date of specimen taken: _____ Time: _____ am/pm

Doctor in Charge (R/SR/C/SC)	Signature and Name of Requesting Doctor	Telephone number

FOR LABORATORY USE ONLY

Processing Cytotechnologist	Service Code	Date/Time Received
	☐ CT0031 FNA ☐ CT0011 Non-Gynae Fluid	