Lab form for HPV/cytology and/or histology samples

Version 1.5 August 2024

Health New Zealand
Te Whatu Ora

Personal details

NHI	
Family name	
Given names	
Preferred name	
Date of birth	dd mm yyyy
Address	
Phone	
Email address	

Personal details continued

Is the person eligible for publicly funded health services?

◯ Yes ◯ No (Provide details of who should be billed below)

Gender

◯ Female ◯ Unknown ◯ Other gender

◯ Male ◯ Unspecified

Clinical presentation

◯ No symptoms ◯ Postmenopausal Bleeding

◯ Abnormal Bleeding ◯ Abnormal cervix

◯ Postcoital Bleeding ◯ Other (enter below)

History

LMP dd mm yyyy

◯ Total hysterectomy

◯ Sub-total hysterectomy

◯ Postmenopausal

◯ HRT

◯ Pregnant, EDD dd mm yyyy

◯ Using oral contraceptives

◯ Use of Depo Provera

◯ Post-partum (< 3 months post-delivery)

◯ Immune deficient

◯ IUCD

◯ Breast feeding

◯ Genital infection

◯ Radiation Therapy

◯ Pessary

◯ Other (enter below)

Test site

◯ Cervical ◯ Endocervical ◯ Vaginal / vault

Specimen type

◯ Vaginal Swab ◯ LBC

Test(s) requested

◯ Swab – HPV

◯ LBC – HPV and cytology if required

◯ LBC – HPV and cytology (co-test)

◯ LBC – cytology only

For gynaecologists, colposcopists and oncologists only

Is this a screening sample? ◯ Yes ◯ No

Histology site

Histology specimen type

◯ Punch biopsy ◯ Total hysterectomy

◯ LLETZ ◯ Sub-total hysterectomy

◯ Cone biopsy ◯ Other (enter below)

Urgent test results

For urgent results provide contact name and phone number

Name	
Phone	

Laboratory identifiers *(Lab to complete)*

Date received by Lab dd mm yyyy

Requestor details

Practitioner name

Health Practitioner Indicator (HPI)

Health Facility Name

Health Facility Number (HPI)

Additional copy of results to

Date taken dd mm yyyy

Signature of Practitioner / Sample taker

Additional comments