HPV GENOTYPING REQUISITION FORM

Identification (Mandatory): printed label preferred	***GenoMed use only*** label
Name:	*Verified by:*

Gender: F ☐ M ☐	Referring doctor:
Date of birth: / /	Hospital/Service:
Identification number:	Telephone or email:

Sample:	**Collection:** Date: ...../...../..... Hour:.....:.....
ThinPrep® / PreservCyt® Solution (Cytyc Corp.) ☐	
SurePath® (BD Diagnostics-TriPath) ☐	
cobas® (Roche Molecular Systems, Inc.) ☐	
Other (with mucolitic agent) ☐ .....……....	

Clinical Data / Relevant Information:

Previous results for HPV genotyping : _____ Date: ___/___/_____

_____ Date: ___/___/_____

31760	HPV – High risk human papillomavirus genotyping	☐
	……	☐

Signature of the Referring Doctor: **Date:**..... /...../.....

Specimen details (to be completed by Consultant Pathologist)

Name of Pathologist:_____

Hospital:_____Telephone:_____

Specimen number:_____

Comments:_____

Date: _____ / _____ / _____ Signature: _____

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IMP 68.4

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