अखिल भारतीय आयुर्विज्ञान संस्थान, राजकोट, गुजरात
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, RAJKOT, GUJARAT
DEPARTMENT OF PATHOLOGY
(Email: aiimspathology21@gmail.com)

EXFOLIATIVE CYTOLOGY REQUISITION FORM

Name:	**Age/Gender:**	**AIIMS CR No.**
Department unit:	**OPD/IPD:**	**Consultant:**
Collection date & time:	**Receiving date and time:**	**Cyto No.**

SPECIMEN	Tick (√) which is applicable
Body fluid	**Pleural/Peritoneal/CSF/Synovial/Pericardial/other**
Bronchial wash/BAL	
Brush cytology	
Rinse cytology	
Urine	
Sputum	
Any other	

Provisional diagnosis & clinical findings:_____

Chief Complaints: _____

Previous cytology no. & diagnosis (if any) _____

Imaging details: _____

Details of fluid container or slide received:_____

FOR PATHOLOGY DEPARTMENT USE ONLY

Date and Time of receipt of sample: _____

If rejected (Reason for rejection) :_____

Number of Container(s)/ slide(s) received: _____

Name and signature of receiving technician: _____

Number of slides submitted: _____

Incharge Resident: _____

Note: If the fluid is not processed within 1 hr of receiving, it should be preserve in refrigerator at 4 digree celcius.

Name of the Resident/Consultant: _____

Phone Number: _____