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**REQUEST FOR CYTOLOGIC EXAMINATION**

DATE \_\_\_\_\_ LABORATORY NUMBER \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

PATIENT'S ADDRESS \_\_\_\_\_

ANATOMIC SITE OF CYTOLOGY SMEAR  
(TONGUE, PALATE, GINGIVA, ETC.) \_\_\_\_\_

DESCRIPTION OF CLINICAL LESION \_\_\_\_\_

\_\_\_\_\_

CLINICAL DIAGNOSIS \_\_\_\_\_

NAME OF SUBMITTING DOCTOR \_\_\_\_\_

DOCTOR'S ADDRESS \_\_\_\_\_

DOCTOR'S PHONE NO. \_\_\_\_\_ FAX NO. \_\_\_\_\_

SIGNATURE OF SUBMITTING DOCTOR \_\_\_\_\_

**CYTOLOGY REPORT:**

**MICROSCOPIC APPEARANCE OF SMEAR**

	NONE	FEW	MANY
ERYTHROCYTES	_____	_____	_____
LEUKOCYTES	_____	_____	_____
HISTIOCYTES	_____	_____	_____
BACTERIA	_____	_____	_____
FUNGI	_____	_____	_____
SQUAMOUS EPITHELIAL CELLS	_____	_____	_____

THE EPITHELIAL CELLS ARE PRIMARILY:  
 BASAL \_\_\_\_ PARABASAL \_\_\_\_ PRECORNIFIED \_\_\_\_ CORNIFIED \_\_\_\_

**CYTOLOGIC GRADING:**

- \_\_\_\_\_ NEGATIVE. ABSENCE OF ATYPICAL CELLS.
- \_\_\_\_\_ SUSPICIOUS. CELLS SUSPICIOUS OF DYSPLASIA OR MALIGNANCY. BIOPSY NECESSARY.
- \_\_\_\_\_ POSITIVE. CELLS SUGGESTIVE OR CONCLUSIVE OF MALIGNANCY. BIOPSY NECESSARY.
- \_\_\_\_\_ UNSATISFACTORY. PLEASE REPEAT SMEAR.

**COMMENT:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ORAL PATHOLOGIST: \_\_\_\_\_ CODE: \_\_\_\_\_