



RELIABLE DIAGNOSTIC LABORATORY NEPAL PVT. LTD.

(PREVENTION IS BETTER THAN CURE)

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PAP Smear Cytology Requisition Form PAP NO:-

Name:		Age:	Date:
Address:	Referred From:		

Menstrual History:

Date of Last Menstrual Period:

Postcoital Bleeding:

IUCD:

Present Complaints: 1)
2)
3)

Gross Examination:

Per Speculum / Colposcopic Examination:

Per Vaginal Examination:

Previous Treatment(Drugs,Hormones,Irradiation):

Previous Surgery (Cervical Biopsy, Ablative Procedures etc.):

Time and Report of previous PAP Smear, if any:

Material Sent: Cervical :
Vaginal :
Vulval :

Clinical Diagnosis:

Consultant's Signature: