For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

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DIAGNOSTIC SERVICES OF MANITOBA
SERVICES DE DIAGNOSTIC DU MANITOBA

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CORE BIOPSIES
HISTOLOGY - BREAST REQUISITION

PHYSICIAN ORDERING TEST:

(Billing Code) _____ (Last Name) _____ (First Name / Initial)

Telephone_____ Pager_____

Copy of report to:

☐ Clinician

(Billing Code) _____ (Last Name) _____ (First Name / Initial)

(Billing Code) _____ (Last Name) _____ (First Name / Initial)

☐ Other Location (ex. diagnostic imaging, CCMB, etc.)

_____
(Name)

PHYSICIAN'S SIGNATURE_____

PATIENT DEMOGRAPHICS (ex. Addressograph imprint):

LOCATION:
WARD

PATIENT NAME:
LAST, FIRST

DATE OF BIRTH
DD/MM/MYYYY

SEX ❑ F ❑ M

FACILITY MRN:

MB PHIN (9 digits):
(or other province, territory or Federal assigning authority such as RCMP, Department of National Defence, Correctional Service Canada, Veterans Affairs Canada, Canadian Immigration (temporary) Health Number)

PHYSICIAN (PRINT):
LAST, FIRST

COLLECTION DATE: D D M M M Y Y Y Y

☐ Referring Institution _____ Contact _____ Telephone: _____
(Site)

PLEASE COMPLETE THE INFORMATION ABOVE, PRINT CLEARLY
***** Specimens may not be examined without the appropriate Demographics and Clinical Information *****

Number of containers: _____ **SPECIMEN SUBMITTED IN:** ☐ **FORMALIN** ☐ **FRESH SPECIMEN** ☐ **OTHER** _____
(ex. Labeled A, B, C, etc.)

Breast biopsy Radiologic Information

Location of lesion: Right or Left _____, _____ o'clock_____cm from Nipple, Depth of lesion _____, Radian _____

Biopsy performed for ***(check or circle all that apply)***:

☐ **Calcifications -** *Type of calcifications:*

☐ Amorphous ☐ Punctate
☐ Heterogeneous ☐ Pleomorphic
☐ Linear/branching ☐ Indeterminate

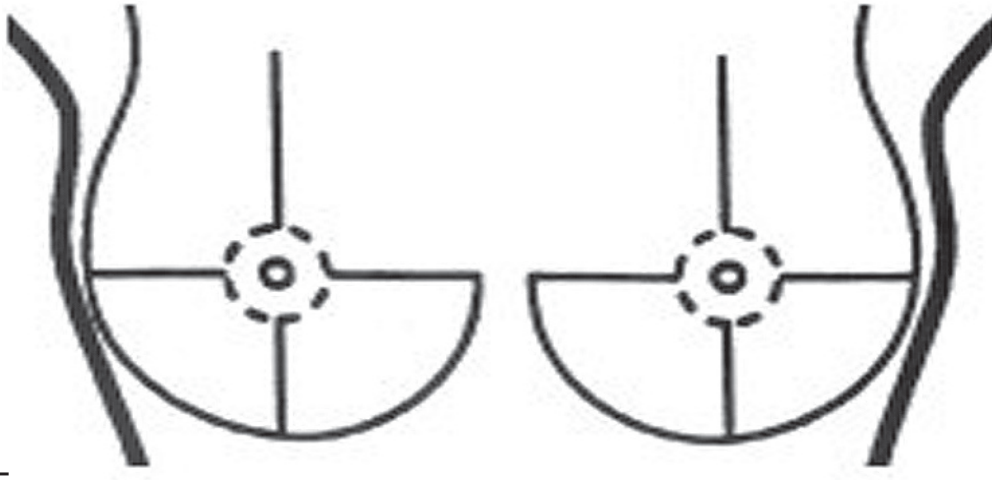
☐ **Mass:**

☐ Palpable ☐ Non-palpable
☐ Solid ☐ Cystic
☐ Mixed solid/cystic

☐ **Architectural distortion**

☐ **Asymmetry**

☐ **Other (i.e. lymph node)** _____



Size of lesion _____

Suspicion based on imaging

☐ Low ☐ Intermediate ☐ High

Comments: _____

Specimen	Time collected	Time in formalin	Sign off Initials
A. _____	24 HOUR	24 HOUR	
B. _____	24 HOUR	24 HOUR	

Breast Requisition Quick Reference

Required Information:
Ordering Physician: Full last/first name required to ensure correct physician ID, and timely contact if consultation required. Include physician billing codes.
Report Copy To: Ensures final report is sent to the appropriate healthcare practitioners involved in patient care map. Ensure billing codes are completed.
Referring Institution: Ensures final reports can be directed accurately & appropriately.
Physician Signature: Physician performing the procedure must sign the requisition to confirm the correct sample on correct patient. **(Mandatory requirement**

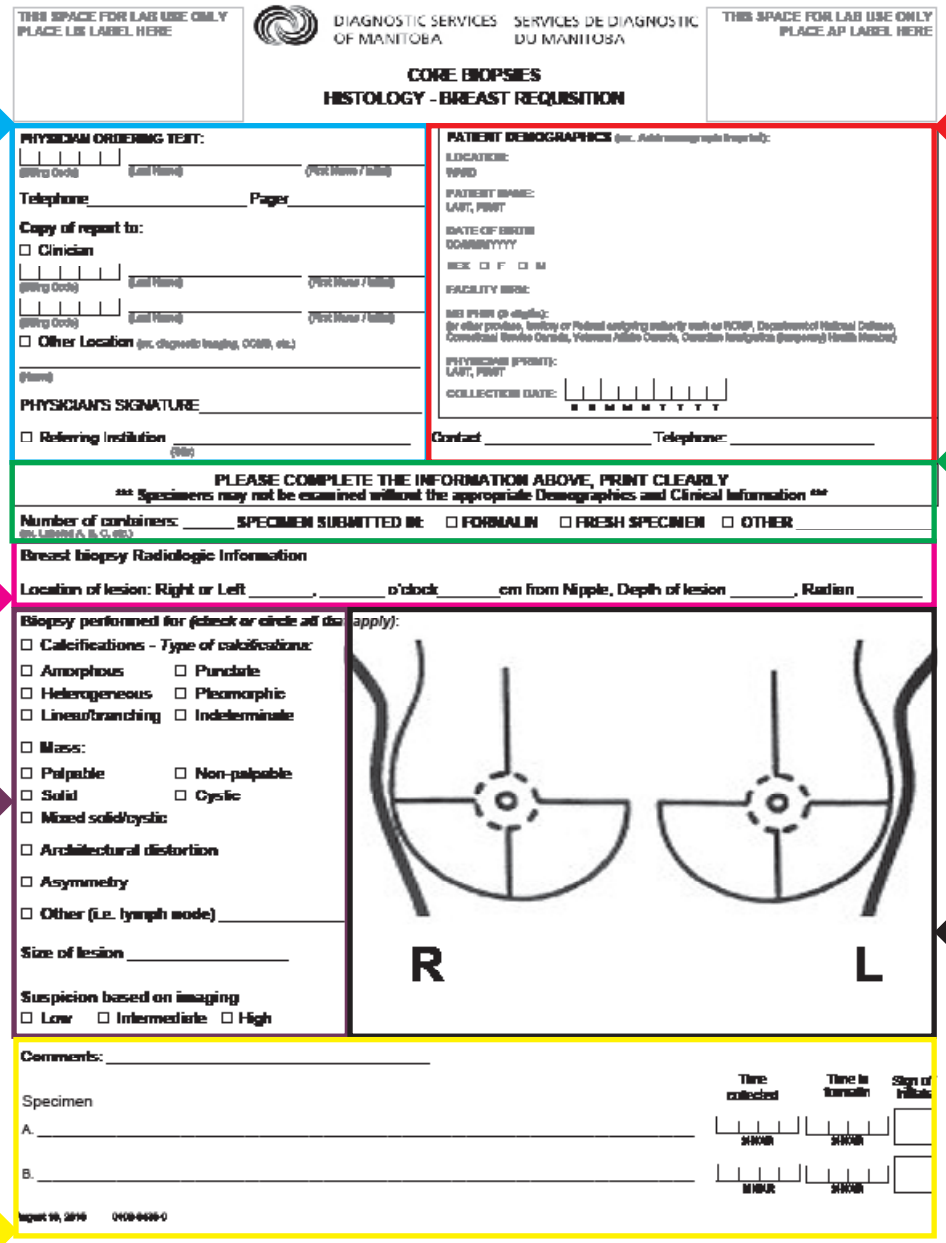
Radiologic Information: Indicate "R" for Right and "L" for Left. This is especially important if multiple or bilateral lesions are present for purposes of radiologic pathologic correlation

Reason for Biopsy:
Suspicion: Use BIRADS if possible

Type of Specimen: Pathology specimens require accurate documentation of specimen source, tissue type, specimen descriptor (mass/tumor etc.), anatomical site including position (left/right)
Indicate presence of calcifications; if applicable

Collection Time: Must be present to ensure accurate fixation times (including ischemic time: time collected). Sign off/initials of person placing specimens into formalin.

Note: Delays in transport to lab may result in potential processing issues.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CORE BIOPSIES
HISTOLOGY - BREAST REQUISITION

PHYSICIAN ORDERING TEST:
(Billing Code) (Last Name) (First Name / Initial)
Telephone _____ Pager _____
Copy of report to:
☐ Clinician
(Billing Code) (Last Name) (First Name / Initial)
(Billing Code) (Last Name) (First Name / Initial)
☐ Other Location (ex. diagnostic imaging, OCMR, etc.)
(Name)
PHYSICIAN'S SIGNATURE _____
☐ Referring Institution _____
(Site)

PATIENT DEMOGRAPHICS (ex. Addressograph if applicable):
LOCATION:
WARD
PATIENT NAME:
LAST, FIRST
DATE OF BIRTH
DD/MM/YYYY
SEX ☐ F ☐ M
FACILITY MRN:
MB PHIN (if eligible):
(for other provinces, territory or Federal assigning authority such as RCMP, Department of National Defense, Correctional Service Canada, Veterans Affairs Canada, Canadian Investigations (Temporary) Health Number)
PHYSICIAN (PRINT):
LAST, FIRST
COLLECTION DATE:
D D M M M Y Y Y Y
Contact _____ Telephone: _____

PLEASE COMPLETE THE INFORMATION ABOVE, PRINT CLEARLY
*** Specimens may not be examined without the appropriate Demographics and Clinical Information ***
Number of containers: _____ SPECIMEN SUBMITTED IN: ☐ FORMALIN ☐ FRESH SPECIMEN ☐ OTHER _____
(ex. Urinary A, B, C, etc.)

Breast biopsy Radiologic Information
Location of lesion: Right or Left _____, _____ o'clock _____cm from Nipple, Depth of lesion _____, Radian _____

Biopsy performed for (check or circle all that apply):
☐ Calcifications - Type of calcifications:
☐ Amorphous ☐ Punctate
☐ Heterogeneous ☐ Pleomorphic
☐ Linear/branching ☐ Indeterminate
☐ Mass:
☐ Palpable ☐ Non-palpable
☐ Solid ☐ Cystic
☐ Mixed solid/cystic
☐ Architectural distortion
☐ Asymmetry
☐ Other (i.e. lymph node) _____
Size of lesion _____
Suspicion based on imaging
☐ Low ☐ Intermediate ☐ High

R L

Comments: _____
Specimen | Time collected | Time in formalin | Sign or Initials
A. _____ HH:MM HH:MM
B. _____ HH:MM HH:MM
Issue 10, 2010 0409-0400-0

Patient Demographics: All patient demographics **MUST** be present & **LEGIBLE**.

Patient last/first name (in full)
- DOB
- Gender
- MB PHIN
- Physician

Critical: Requisition ***MUST*** match Specimen Label

Number of Specimens: Required to confirm physical quantity matches documented at time of collection. With multiple specimens – label alphabetically.
Specimen Submitted In: e.g. Formalin, fresh, etc. Required to ensure appropriate handling and specimen processing.
Required to ensure appropriate handling and specimen processing.

Location: Note on the diagram the lesion being biopsied, location, size, and other relevant findings like skin changes, nipple retraction, scars, etc. These are required to support the pathologist interpretation.

Important
The information required for completion of the Pathology Services Laboratory Requisition is the minimum standard to ensure compliance to:
- DSM Specimen Acceptance Policy #10-50-04
- CAP accreditation requirements
- Positive patient/specimen identification & verification.

Lack of clinical details will impede diagnosis and will ultimately delay cases which may impact to the quality of the final diagnostic report.