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.

THIS SPACE FOR LAB USE ONLY
PLACE LIS LABEL HERE

DIAGNOSTIC SERVICES OF MANITOBA
SERVICES DE DIAGNOSTIC DU MANITOBA

THIS SPACE FOR LAB USE ONLY
PLACE AP LABEL HERE

PATHOLOGY SERVICES
HISTOLOGY - BREAST REQUISITION - EXCISION

PHYSICIAN ORDERING TEST:

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

Telephone_____ Address_____

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

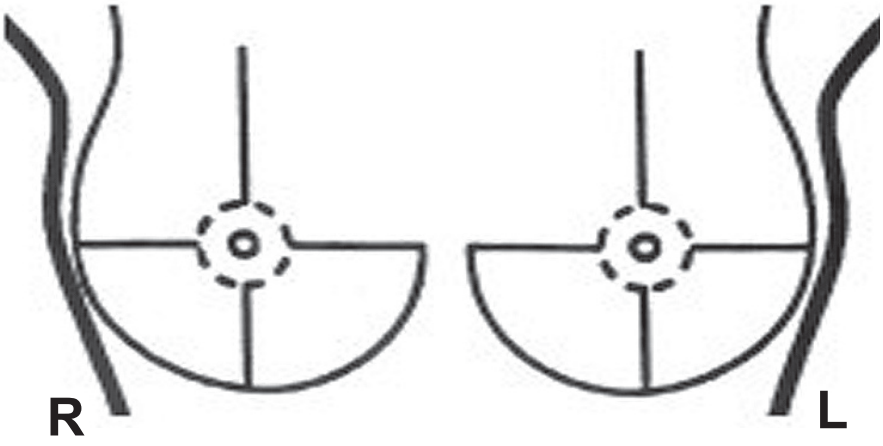
☐ Referring Institution _____ Contact _____ Telephone: _____
(Site) (Address)

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

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

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

LOCATION:



History:

Preop core biopsy? ☐ Yes ☐ No
Previous breast surgery ☐ Yes ☐ No
☐ Ipsilateral ☐ Contralateral
Path number _____ (If available)
Markers/clips placed ☐ Yes ☐ No
Multifocal? ☐ Yes ☐ No Number of foci _____
Distance between lesions _____
Size of largest focus _____mm ☐ Clinical ☐ Imaging
Neoadjuvant Radio/Chemo/Endocrine therapy? ☐ Yes ☐ No
Other: _____ (BRCA status, etc.)

Procedure:

☐ Lumpectomy Wire localized ☐ Yes ☐ No
☐ Mastectomy
☐ Sentinel lymph node biopsy
☐ Axillary dissection

Intraoperative Consultation: _____

Specimen	Ischemic Start Time: Time collected	Time in formalin
A. _____	24 HOUR	24 HOUR
B. _____	24 HOUR	24 HOUR
C. _____	24 HOUR	24 HOUR
D. _____	24 HOUR	24 HOUR
E. _____	24 HOUR	24 HOUR
F. _____	24 HOUR	24 HOUR
G. _____	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/Referring Institution: Ensures final report is sent to the appropriate healthcare practitioners involved in patient care map. Ensure billing codes are completed.
Physician Signature: Physician performing the procedure must sign the requisition to confirm the correct sample on correct patient. **(Mandatory requirement)**

Critical: Complete and accurate information is necessary to ensure final reports are directed appropriately.

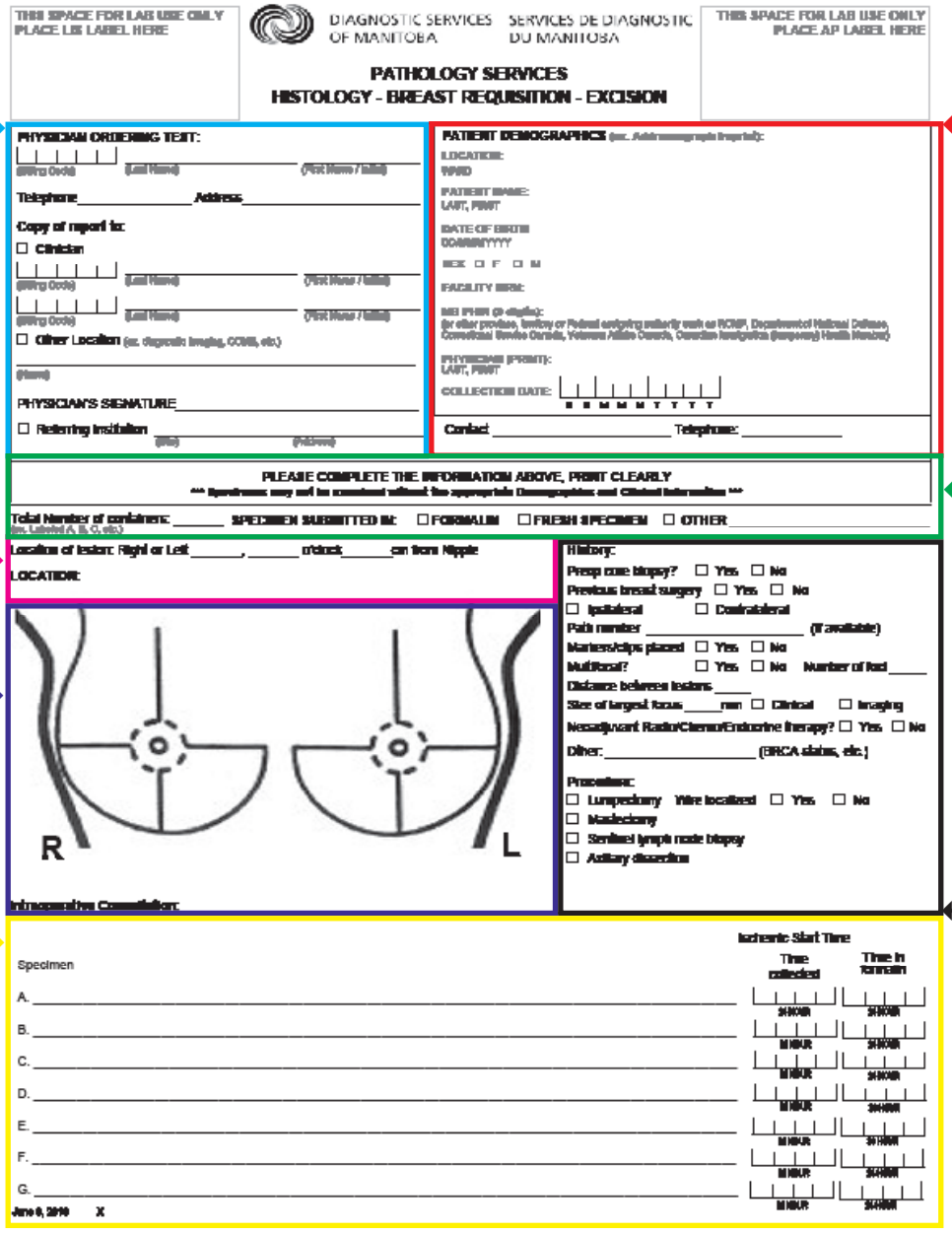
Radiologic Information:

Location: Note on the diagram the tumor location.

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

Collection Time: **Mandatory: Include both ischemic time and time in formalin (if not submitted fresh to the pathology department).** For biomarker test results to be valid, the cold ischemic time (time from removal of patient to initiation of fixation) must be < 1 hour. These time points must be recorded to document that tissue is handed from the surgical field and placed in fixative as quickly as possible.

Place initials beside the time in formalin.
Note: *Delays in transport to lab may result in potential processing issues.*



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

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: Required to ensure appropriate handling and processing specimens.

Reason for excision and clinical history pertaining to this specimen.

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.