DIAGNOSTIC SERVICES MANITOBA | SERVICES DIAGNOSTIC MANITOBA

MORRIS LABORATORY REQUEST FORM

Box 519
215 Railroad Ave. E.
Morris, MB R0G 1K0
204-746-7355 Fax 204-746-2445

Surname _____ **Given Name** _____ **Sex:** M F

Alias _____ **Phone No.** _____

DOB D/M/Y _____ **Hospital/Clinic #** _____

PHIN _____ **MHSC** _____

Patient Address _____

Physician _____ **Billing Code** _____

Physician Phone No: _____

Physician Critical Results Phone Number _____

IP-RM#_____ **OPD** **Clinic** **PCH** **Referred In** **Other** _____

Routine **Pre-Op** **ASAP** **STAT**

Prepared by: _____

Date: _____ **Draw Time:** _____ **Tech:** _____

Notes: _____

( ) WBC		( ) RBC	( ) Hemoglobin
( ) Hematocrit		( ) MCV	( ) MCH
( ) MCHC		( ) Platelets	
( ) Auto Diff	5 part automated diff as per follow up protocol		
( ) Auto Diff, Manual diff	5 part automated diff and manual diff as per protocol		
( ) Auto Diff, Manual smear	5 part automated diff and manual smear assessment as per protocol		

Technologist(s): _____ **Date:** _____