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

PATHOLOGY SERVICES

LABORATORY REQUISITION

THIS SPACE FOR LAB USE ONLY
PLACE AP LABEL HERE

NAME OF PHYSICIAN ORDERING TEST: ..... (LAST) ..... (FIRST)

Copy of report to: ....

Address ....

Fax/Phone ....

REFERRING INSTITUTION NAME AND ADDRESS OR CODE (FOR EXTERNAL LOCATIONS): .....

CONTACT .....

TELEPHONE ..... PAGER .....

PHYSICIAN'S SIGNATURE .....

LOCATION/WARD: .....

PATIENT NAME: ..... (LAST) ..... (FIRST)

DATE OF BIRTH: ..... DD/MM/YYYY GENDER: ☐ M ☐ F

FACILITY HEALTH RECORD NO.: .....

PERSONAL HEALTH ID NO. (PHIN): .... (PROV. OR INST.)

PHYSICIAN (PRINT): ..... (LAST) ..... (FIRST)

COLLECTION DATE and TIME: .....

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

# of SPECIMENS: _____

SPECIMEN SUBMITTED IN: ☐ **FORMALIN** ☐ **SALINE** ☐ **TRANSPORT MEDIA** ☐ **OTHER** _____

TYPE OF SPECIMEN(S):
(with exact location and orientation)

FOR GYNECOLOGICAL SPECIMENS GIVE:

Date of Last Menses _____

Para _____ Gravida _____

I.U.D., Hormone Therapy _____

INTRAOPERATIVE CONSULTATION:

Pathologist Signature .....

TYPE OF OPERATION/PROCEDURE:

CLINICAL DATA, e.g. DIAGNOSIS, X-RAY FINDINGS, RADIATION, CHEMO/DRUG THERAPY (current and previous):

PREVIOUS SURGICAL PATHOLOGY AND CYTOLOGY REPORTS:

SPECIAL REQUESTS FOR HSC ONLY:

☐ ELECTRON MICROSCOPY
☐ HORMONE RECEPTORS
☐ IMMUNOFLUORESCENCE
☐ LYMPHOMA PROTOCOL
☐ PERINATAL LOSS: OPTION A _____; OPTION B _____ (please attach release form)
☐ RESEARCH PROTOCOL _____
☐ TISSUE FOR RETURN
☐ OTHER _____

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