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DIAGNOSTIC SERVICES OF MANITOBA | SERVICES DE DIAGNOSTIC DU MANITOBA

PATHOLOGY SERVICES

LABORATORY REQUISITION

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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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FORM # 80993 ITEM # 1503 12/08