



DIAGNOSTIC SERVICES MANITOBA SERVICES DIAGNOSTIC MANITOBA



Hôpital St-Boniface Hospital

LOCATION:
WARD

PATIENT NAME:
LAST, FIRST

DATE OF BIRTH:
DD/MMM/YYYY

SEX F M

FACILITY MRN:

MB PHIN:
(Specify province if different)

PHYSICIAN: (PRINT)
LAST, FIRST

ORDERING PROFESSIONAL:
(If different from physician)

COLLECTION TIME & DATE:

Hr / Min Day / Month / Year

____/____ ____/____/____

COLLECTED BY:

NAME, INITIALS _____

BIOCHEMISTRY TEST REQUISITION

Test Code to be registered: _____ INST _____

INSULIN STIMULATION

	0 Min	15 Min	30 Min	45 Min	60 Min	90 Min	120 Min
GLUCOSE							
CORTISOL							
GH							

HSC Lab Staff: Enter results on worksheet INST.
Print SGHH worksheet for GH Send-Out.
Report GH results on worksheet GHS1.

SBH Lab Staff: Enter results on worksheets GS1, INST.
Print SGHB worksheet for GH Send-Out.
Report GH results on worksheet GHS1.