



DIAGNOSTIC SERVICES SERVICES DIAGNOSTIC
MANITOBA MANITOBA



Hôpital St-Boniface Hospital

LOCATION:
WARD

PATIENT NAME:
LAST, FIRST

DATE OF BIRTH:
DD/MM/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: _____ DBLM _____

TRH/GnRH STIMULATION MALE

	0 Min	15 Min	30 Min	60 Min
CORTISOL		-----	-----	-----
FT4		-----	-----	-----
FT3		-----	-----	-----
TESTOSTERONE		-----	-----	-----
TSH				
FSH				
LH				
PROLACTIN				

Lab Staff: Enter results on worksheet DBL