



DIAGNOSTIC SERVICES SERVICES DIAGNOSTIC
MANITOBA 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: _____ TRTS _____

TRH/TSH STIMULATION

	0 Min	15 Min	30 Min	60 Min
FT4		----- -	----- -	----- -
FT3		----- -	----- -	----- -
TSH				

Lab Staff: Enter results on worksheet TRTS