



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

### WARD USE ONLY

Test Code to be registered: \_\_\_\_\_ ACS \_\_\_\_\_

## ACTH (Cosyntropin) STIMULATION (REGULAR DOSE)

	0 Min	30 Min	60 Min
CORTISOL			

Lab Staff: Enter results on Worksheet ACS.