THIS SPACE FOR LAB USE ONLY
PLACE LIS LABEL HERE

DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTICS MANITOBA

PATHOLOGY SERVICES LABORATORY REQUISITION

THIS SPACE FOR LAB USE ONLY
PLACE AP LABEL HERE

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 .....
Critical Results Phone #
TELEPHONE ..... PAGER .....

PHYSICIAN'S SIGNATURE .....

LOCATION:
WARD

PATIENT NAME:
LAST, FIRST

PATIENT PHONE #:

DATE OF BIRTH
DD/MM/YYYY

SEX ❑ F ❑ M

FACILITY MRN:

MB PHIN:
(Specify Province if different)

PHYSICIAN (PRINT):
LAST, FIRST

PHYSICIAN BILLING CODE:

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:

Hôpital général St-Boniface General Hospital
ST. BONIFACE GENERAL HOSPITAL
409 Taché Avenue