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DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTICS MANITOBA

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PATHOLOGY SERVICES LABORATORY REQUISITION

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:

TYPE OF OPERATION/PROCEDURE:

CLINICAL DATA, e.g. DIAGNOSIS, X-RAY FINDINGS,
RADIATION, CHEMO/DRUG THERAPY (current and previous):

Pathologist Signature

PREVIOUS SURGICAL PATHOLOGY AND CYTOLOGY REPORTS: