THIS SPACE FOR LAB USE ONLY:
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DIAGNOSTIC SERVICES OF MANITOBA
SERVICES DE DIAGNOSTIC DU MANITOBA

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PATHOLOGY SERVICES

LABORATORY TEST 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 .....

TELEPHONE..... PAGER.....

PHYSICIAN'S SIGNATURE.....

LOCATION/WARD: .....

PATIENT NAME: ....
(LAST) (FIRST)

DATE OF BIRTH: ..... SEX: ☐ M ☐ F
(DD/MMM/YYYY)

FACILITY HEALTH RECORDS NO: .....

PERSONAL HEALTH ID NO (PHIN): ....
(PROV. OR INST.)

PHYSICIAN (PRINT): ....
(LAST) (FIRST)

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:

Westman Lab

Westman Laboratory
Unit 1 – 150 McTavish Aveune
Brandon, Manitoba R7A 7H8 Ph: (204) 578-4440