THIS SPACE FOR LAB USE ONLY:
PLACE LIS LABEL HERE

DIAGNOSTIC SERVICES OF MANITOBA
SERVICES DE DIAGNOSTIC DU MANITOBA

THIS SPACE FOR LAB USE ONLY:
PLACE AP LABEL HERE

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.............................. Physician Critical Values Phone # ....

Please use this section for addresso-graph or pre-printed patient labels

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: