For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

THIS SPACE FOR LAB USE ONLY
PLACE LIS LABEL HERE

DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTICS MANITOBA

THIS SPACE FOR LAB USE ONLY
PLACE AP LABEL HERE

NON-GYNAECOLOGICAL CYTOLOGY
LABORATORY REQUISITION
DEPARTMENT OF PATHOLOGY

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 CRITICAL RESULTS PH. NUMBER.....

PHYSICIAN'S SIGNATURE .....

LOCATION/WARD: .....

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

DATE OF BIRTH: ..... DD/MM/YYYY GENDER: ☐ M ☐ F

FACILITY HEALTH RECORD NO.: .....

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

PATIENT PHONE #: .....

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 *****

***SPECIMENS MUST BE IDENTIFIED WITH PATIENT NAME, PHIN, AND SPECIMEN SITE.**

INVESTIGATION REQUIRED: ☐ TUMOR CELLS ☐ OTHER (specify) _____

TYPE OF SPECIMEN: (with ***exact*** location)

☐ BAL ☐ Right ☐ Left
☐ Bronchial wash ☐ Right ☐ Left
☐ Bronchial brush ☐ Right ☐ Left
☐ Urine ☐ Voided ☐ Catheterized
☐ Breast ☐ Right ☐ Left
☐ FNA (specify site) _____
☐ Other (specify) _____

☐ Sputum
☐ Pleural
☐ Peritoneal ☐ Fluid ☐ Washing
☐ Pericardial Fluid
☐ CSF

CLINICAL DATA:

Any previous tumors (malignant or benign) _____

Please list all relevant clinical information.

Westman Laboratory
150 McTavish Avenue E
Brandon, MB R7A 7H8
204-578-4440