THIS SPACE FOR LAB USE ONLY
PLACE LIS LABEL HERE

DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTICS MANITOBA

PATHOLOGY SERVICES LABORATORY REQUISITION

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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:

☐ Bethesda Hosp Lab, 316 Henry St, Steinbach, MB, R5G 0P9
☐ DeSalaberry DHC Lab, 454 Prefontaine Ave, St Pierre, MB, R0A 1V0
☐ Ste. Anne Hosp Lab, 52 St Gerard Street, Ste Anne, MB, R5H 1C4
☐ Vita & DHC Lab, 217-1st Avenue West, Vita, MB R0A 2K0