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:

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: