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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.....

Please use this section for addressograph 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: