

Histopathology lab phone 604-877-6000 # 2086 fax 604-877-6038

HISTOPATHOLOGY REQUISITION

Shaded fields must be completed LEGIBLY (patient demographics may be addressographed instead).

Patient Name Last First PHN Expiry date (mm/yy) /

Date of Birth (dd/mmm/yy) Sex M F **BCCA patient** Y N **BCCA No.** _____

Requesting Physician MSC

Address

Report copy to (all information is necessary to receive a report)

Name: _____ MSC _____ Address _____

Name: _____ MSC _____ Address _____

Clinical/Radiological summary _____

Lack of clinical history may result in sub optimal interpretation

Specimen sites **Date taken** (dd/mmm/yy) / / **Lymphoma** **Urgent**
Time taken Time into fixative

A	_____	:	:
B	_____	:	:
C	_____	:	:
D	_____	:	:
E	_____	:	:
F	_____	:	:
G	_____	:	:
H	_____	:	:

Sent by _____ Dept/Site _____ Number of containers _____

Lab use only

Time out of formalin _____ :

Demographics checked	Initials
Received	
Number of containers ()	
Accessioning	
Grossing	
Assigned	
Pathologist	