Provincial Health Services Authority
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Addressograph/Patient Label Only

Pathology Office: Phone 604-877-6000 # 672071, 672069, 672061, 672053
: Fax 604-877-6178

PATHOLOGY REVIEW REQUEST FORM

All fields must be completed LEGIBLY (Patient demographics must be filled in, if not addressographed).

Patient Name (Last, First) _____, _____ **PHN** _____

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

Requesting Physician _____ **MSC** _____

Phone # _____ **Fax #** _____

Originating Hospital _____ **Pathology Specimen #** _____

Copy to:- Name _____ **MSC #** _____ **Phone #** _____

Copy to:- Name _____ **MSC #** _____ **Phone #** _____

❑ **Urgent** ❑ **Routine**

❑ **Endocrine** ❑ **Gastrointestinal (GI)** ❑ **Gyne** ❑ **Head/Neck** ❑ **Lung**

❑ **Lymphoma** ❑ **Prostate/GU** ❑ **Skin/Melanoma**

❑ **Soft Tissue**

❑ **Primary Unknown** ❑ **Other (specify)** _____

❑ **Breast (Node Negative)** ❑ **Y** ❑ **N**

Particular morphological aspects to be reviewed _____

_____

_____

When completed please fax this requisition to: Pathology Office 604-877-6178

Jan 2019 rgg