Provincial Health Services Authority
Province-wide solutions. Better health.

BC CANCER
Provincial Health Services Authority

Addressograph/Patient Label Only

PATHOLOGY REVIEW REQUEST FORM

All Fields Must Be Completed LEGIBLY (Patient demographics must be filled in, if not addressographed).

PATIENT NAME (LAST, FIRST):

DATE OF BIRTH (dd/mmm/yy): **SEX: M F U X**

PERSONAL HEALTH NUMBER (PHN):

BC CANCER PATIENT: Y N **CERNER MEDICAL RECORD NUMBER (MRN):**

REQUESTING PHYSICIAN (LAST, FIRST): **MSP NUMBER:**

PHONE NUMBER: **FAX NUMBER:**

COPY TO: NAME (LAST, FIRST): **MSP NUMBER:** **PHONE NUMBER:**

COPY TO: NAME (LAST, FIRST): **MSP NUMBER:** **PHONE NUMBER:**

ORIGINATING HOSPITAL: **PATHOLOGY SPECIMEN NUMBER:**

❑ **URGENT** ❑ **ROUTINE**

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

❑ **Lymph Node** ❑ **Prostate/Genitourinary (GU)** ❑ **Skin/Melanoma**

❑ **Soft Tissue** ❑ **Oral**

❑ **Primary Unknown** ❑ **Other (Specify):**

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

Specific Morphological Aspects To Be Reviewed:

Fax requisition to Pathology Office when completed: 604-877-6178
Any questions, please contact: BCCAPathClerks@bccancer.bc.ca

REQUESTING PHYSICIAN SIGNATURE:

DATE SIGNED:

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.

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