Reset form

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Path Accession Number _____

OUTPATIENT PATHOLOGY CONSULTATION REQUISITION

ARH & CC
32900 Marshall Rd.
Abbotsford, B.C. V2S 0C2
Phone (604) 851-4857
Fax (604) 851-4858

Patient Name: _____
Last First

Date of Birth: _____ Sex: ☐ M ☐ F
DD/MM/YYYY

PHN: _____

Doctor: _____

Insurance: MSP
MSP, Self pay, Out of Prov., WCB, RCMP, Veterans, and Refugee etc.

DATE OF PROCEDURE: _____
DD/MM/YYYY

Patient Address: _____

City: _____ Province: BC Country: Canada

Postal Code: _____ Phone: _____

1. **ALL Patient Demographics must be printed legibly and completed in full**
2. **The anatomic site and relevant clinical information are essential for an accurate pathological consultation. Failure to provide this information may result in delayed report.**
3. **All specimens to be submitted in 10% buffered Formalin, except with prior consultation with a Pathologist.**
4. **All additional copy physicians must have first and last name and MSP number.**
5. **All Non Canadian Residents must sign a FHA waiver form. The signed and witnessed form must be attached to the requisition when specimen submitted.**

Number of containers submitted _____ List below specimen type / site:

1. _____ 3. _____

2. _____ 4. _____

HISTORY AND CLINICAL DIAGNOSIS:

DOCTOR(S) COPIES TO: (must include MSP numbers): _____

_____
SIGNATURE / STAMP OF REQUESTING DOCTOR

_____
MSP NUMBER OF REQUESTING DOCTOR

LAB USE ONLY:

INITIALS OF TECHNOLOGIST / AIDE SPECIMENS	NUMBER OF CONTAINERS RECEIVED BY LAB	DATE VERIFYING
_____	_____	_____