



Path Accession Number _____

OUTPATIENT PATHOLOGY CONSULTATION REQUISITION

Burnaby Hospital Phone (604) 412-6245
3935 Kincaid St. Fax (604) 431-2806
Burnaby, B.C. V5G 2X6

Patient Name: _____
Last First

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

PHN: _____

Doctor: _____

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

DATE OF PROCEDURE: _____
DD/MM/YYYY

Patient Address: _____

City: _____ Province: _____ Country: _____

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