



Path Accession Number \_\_\_\_\_

### OUTPATIENT PATHOLOGY CONSULTATION REQUISITION

**Royal Columbian Hospital** Phone (604) 520-4352  
330 E Columbia St. Fax (604) 520-4409  
New Westminster, B.C. V3L 3W7

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.

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