

VIROLOGY and REFERENCE LABORATORY St. Paul's Hospital 6 th Floor, Burrard Bld. 1081 Burrard St. Vancouver, B.C. V6Z 1Y6 Ph: 604-806-8420		Name _____ <small style="margin-left: 100px;">Last</small> <small style="margin-left: 200px;">First</small>
		DOB: _____ SEX: M F <small style="margin-left: 20px;">Day</small> <small style="margin-left: 40px;">Month</small> <small style="margin-left: 40px;">Year</small>
		Healthcare # _____ Prov: _____
Date of Collection: _____ <small style="margin-left: 100px;">Day</small> <small style="margin-left: 40px;">Month</small> <small style="margin-left: 40px;">Year</small>		Doctor: _____
Chlamydia + GC PCR <input type="checkbox"/> Cervix <input type="checkbox"/> Urine <input type="checkbox"/> Endocervix <input type="checkbox"/> Urethral		Location/Clinic: _____ Ph: _____ Billing# _____ Copies to: _____ _____
Shipper: 04323 Whitehorse General Hospital Laboratory # 5 Hospital Rd Whitehorse, YT Y1A 3H7		Clinical Data: Pregnancy: weeks gestation _____ Date of onset of disease: _____ Diagnosis (provisional) _____
Date Received: _____	Lab Code: _____	Blood Borne Precautions: <input type="checkbox"/> Y <input type="checkbox"/> N