☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

DEPARTMENT OF PATHOLOGY SURGICAL REQUISITION

Date of Surgery: ______________________________

Apply Patient Label

Copy to: WHITEHORSE GENERAL HOSPITAL
LABORATORY
#5 HOSPITAL ROAD
04323 WHITEHORSE, YT Y1A 3H7

Bill to: ☐ MSP ☐ WCB ☐ RCMP ☐ Self pay ☐ Other

	EXACT SOURCE OF THE SPECIMEN	Time taken	Time into fixative
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			

Blank space for drawing orientation of specimen

Clinical diagnosis, history and additional information (including any previous relevant surgery)
Lack of clinical history may result in sub-optimal interpretation.

DEPARTMENT USE ONLY

Number of Frozen Sections: ______________

GROSS DIAGNOSIS: ______________________

RUSH DIAGNOSIS: ______________________

Pathologist: ______________________

Surgeon printed name: ______________________ Signature: ______________________

Copies to: ______________________ Dr. billing number: ______________________
(Please provide)

Form No. PHC-LA124 (R. Jan-11)