

**SENDER INFORMATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Protected B when complete

# REQUISITION FOR MUMPS GENOTYPING (BULK SUBMISSION)

**Viral Exanthemata & STDs - Measles, Mumps and Rubella Unit**  
 National Microbiology Laboratory  
 1015 Arlington Street, Winnipeg, MB R3E 3R2  
 Telephone: (204) 789-6024 Fax: (204) 318-2222

UNIQUE PATIENT IDENTIFIER (NAME, CODE OR MEDICAL HEALTH #)	DATE OF BIRTH (YYYY-MM-DD)	GENDER	SPECIMEN REF#	COLLECTION DATE (YYYY-MM-DD)	SPECIMEN INFORMATION	DATE OF ONSET (YYYY-MM-DD)	TRAVEL HISTORY/ ADDITIONAL INFORMATION	MUMPS RT-PCR RESULT (CP/CT VALUE)
		<input type="radio"/> M <input type="radio"/> F			<input type="checkbox"/> BUCCAL SWAB <input type="checkbox"/> URINE <input type="checkbox"/> OTHER (SPECIFY): _____			
		<input type="radio"/> M <input type="radio"/> F			<input type="checkbox"/> BUCCAL SWAB <input type="checkbox"/> URINE <input type="checkbox"/> OTHER (SPECIFY): _____			
		<input type="radio"/> M <input type="radio"/> F			<input type="checkbox"/> BUCCAL SWAB <input type="checkbox"/> URINE <input type="checkbox"/> OTHER (SPECIFY): _____			
		<input type="radio"/> M <input type="radio"/> F			<input type="checkbox"/> BUCCAL SWAB <input type="checkbox"/> URINE <input type="checkbox"/> OTHER (SPECIFY): _____			
		<input type="radio"/> M <input type="radio"/> F			<input type="checkbox"/> BUCCAL SWAB <input type="checkbox"/> URINE <input type="checkbox"/> OTHER (SPECIFY): _____			

The National Microbiology Laboratory (NML) of the Public Health Agency of Canada (PHAC) provides reference diagnostic services free of charge. The Client and NML agree that this requisition acts as an agreement for the NML to provide testing, as described in the Guide to Services, for the above requested tests.