



REQUISITION FOR VACCINE PREVENTABLE BACTERIAL DISEASES REFERENCE TESTING

Syphilis Diagnostics and Vaccine Preventable Bacterial Diseases

National Microbiology Laboratory
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SENDER INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____

PROVINCE: _____

POSTAL CODE: _____

TELEPHONE: _____

FAX: _____

PATIENT INFORMATION

PATIENT INITIALS: _____

DATE OF BIRTH (YYYY-MM-DD): _____

SEX M F

CITY: _____

OTHER INFORMATION: _____

SPECIMEN INFORMATION

SPECIMEN REF #: _____

COLLECTION DATE (YYYY-MM-DD): _____

DATE OF DISEASE ONSET (YYYY-MM-DD): _____

SOURCE OF SPECIMEN: _____

SUSPECTED PATHOGEN

TEST REQUIRED

CLINICAL HISTORY

CLINICAL DIAGNOSIS, SYMPTOMS: _____

PREVIOUS LAB RESULTS: _____

VACCINE HISTORY: _____

COMMENTS