For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

CLONIDINE STIMULATION TEST

Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection

Ordering Provider Information			**Patient Information** *(print or use addressograph)*
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)
Inpatient Location:	*Critical Results Ph #:		* Date of Birth (dd/mm/yyyy) *Sex: □ Female □ Male
*Facility Name/ Address			
Ph #:	Fax #:		*PHIN: Specify Province or DND if different MRN:
Copy Report To *(if info missing, report may not be sent)*:			Encounter #:
Last & Full First Name:	Ph #:	Fax #:	Patient Ph #:
Facility Name/ Address:			Patient Address:
Last & Full First Name:	Ph #:	Fax #:	
Facility Name/ Address:			Demographics verified via: ❑ Health Card ❑ Armband ❑eChart/CR ❑Other

Collection Information (fields marked with ♦ required by person collecting sample)	
♦Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Arterial Puncture	♦ Collector: ♦ Collection Facility/Lab:

CLONIDINE STIMULATION TEST

(Test code: CLDN)

♦Collection Date: _____ ♦Collection Time: _____

Clearly label tube with appropriate time point. Submit separate requisition for each time point.

	0 Min	30 Min	60 Min	90 Min	120 Min
CORTISOL					
GH					

Lab Staff: Enter cortisol results on worksheet CLDN.
Report GH results on worksheet GHS8.