Centre Medico Social
Desalaberry District Health Centre
Box 320, 354 Prefontaine Ave
St-Pierre, MB R0A 1V0
Ph. (204) 433-7611 Lab Fax (204) 433-7866

DIAGNOSTIC ORDERS

Patient Last/First Name:
Date of Birth:
PHIN:
Patient Phone #:

Physician Name:
Physician Phone #:
Physician Critical Results Phone #:

______ Check if Fasting

HEMATOLOGY (LV tube)

Test	Lab Codes
CBC (includes WBC diff)	CBC
ESR	ESR
RETIC	RETA
Inf. MONO	MS

(LB tube)

Test	Lab Codes
INR	PT
PTT(for Heparin therapy)	APTT

CHEMISTRY (LG tube)

Test	Lab Codes
Glucose ☐ Fasting ☐ Random	G
Sodium	NAR
Potassium	KR
Chloride	CLR
Urea	U
Creatinine	CR
eGFR	EGFR
TCO2	CO2
Calcium	CA
Phosphorous	P
Magnesium	MG
Uric Acid	UA
Bilirubin, Total	TB
Bilirubin, Direct	DB
Alk Phos	ALKP
ALT	ALTR
AST	ASTR
GGT	GGT
Total Protein	TP
Albumin	AL
LDH	LDH
Lipase	LIPA
Quant Serum BHCG	HCGQ
CK	CK
Troponin I	TIWB

LIPOPROTEIN PROFILE

☐ Fasting ☐ Random

Includes: Chol, Trig, HDL/LDL LIPP

Blood Gas __Venous VGAS
__Arterial AGAS
__Capiliary AGAS

Blood Cultures BLD 1&2
(St.Boniface Microbiology Req) ☐

URINE

Test	Lab Codes
Urinalysis	UR
Urine C&S (Cadham)	☐
Pregnancy Test(Qual)	PREG
Cytology	

SWABS

Test	Lab Codes
Trichomonas	TVA
Rapid Strep	SATA
Bacterial Vaginosis	BVAG
(St-B Micro Req)	☐
Vaginal C&S(incl. C. Albicans)	
(Cadham Req)	☐

STOOL

Test	Lab Codes
FOB	OB
C&S ______ C.Diff	
O&P	

Make a separate requisition for patient to take back to lab with their samples

Fluids ☐ Synovial ☐ Pleural

Site:________________

Test	Lab Codes
Cell count	HFLD
Other (Please Specify): ________________ ________________	
C&S(St.B Micro Req)	☐

SEROLOGY(Separate Cadham Req) ☐

- STI Panel
- Post-Exposure-Exposed Panel
- Post-Exposure-Source Panel
- Prenatal Panel
- HAV IgG (Immunity)
- HBsAb (Immunity)
- HAV IgM(Acute HAV)
- HBsAg
- HBcAb (total)
- HCV Ab
- Syhilis Screen
- H. Pylori
- Lyme disease
- West Nile Virus

Other tests (print clearly)

DRUG LEVELS

Test	Lab Codes
Salicylate	SAL
Acetaminophen	ACTM
Dilantin/Phenytoin	PYN
Digoxin	DIG
Lithium	LI
Carbamazepine	CARB
Gentamicin Trough	GENTT
Gentamicin Peak	GENTP
Other:________________	

Please include: TDOS
Last Dose Date/Time:________________
Next Dose Date/Time:________________

DRUG SCREEN (urine) STRE
(Separate St-Boniface req.) ☐
Note: Street Drug Screen does not include Ethanol

WESTMAN LAB(Seperate req.) ☐

Test	Lab Codes
Hemoglobin A1C	GYHB
Random Microalbumin	RMA
TSH	TSH
T3	FT3
T4	FT4
PSA	PRSA
Ferritin	FER
Vitamin B12	B12
C-Reactive Protein	CRP
Rheumatoid Factor	RF

Lab Use Only

Coll By:____________Time:__________

Tubes Collected:
LG_______ RD_______
LV_______ SO_______
LB_______
GD_______ ILV_______