

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.

IERHA Downtime Laboratory Request and Report



DIAGNOSTIC SERVICES
MANITOBA

SERVICES DIAGNOSTIC
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Name of physician ordering tests Clinic name and address Phone _____ Fax _____	Patient Name Patient Phone Number PHIN Date of Birth Female <input type="checkbox"/> Male <input type="checkbox"/>
If an additional report is required, please complete the following Name of physician Clinic name and address Phone _____ Fax _____	Reference # P Patient demographics checked by MHSC <input type="checkbox"/> armband <input type="checkbox"/> echart <input type="checkbox"/>
Physician Critical Results Phone Number	Date _____ Time _____ Collected by _____ Collected at _____

Hematology

TEST

CBC (CBC) (Automated WBC Differential Included) L (See separate report)

TEST	RESULT	REFERENCE RANGE	UNITS	Age/ Gender Dependand
<input type="checkbox"/> ESR (ESR)	_____	0 - 20 0 - 15 0 - 10	mm/hr mm/hr mm/hr	Female Male Child

Coagulation

TEST	RESULT	REFERENCE RANGE	UNITS	Therapeutic
<input type="checkbox"/> INR (PT)	_____	0.9 -1.1		

Microbiology

Miscellaneous

TEST	RESULT	TEST	RESULT
Group A antigen Detection (SATA) _____		Pregnancy Test (PREG) (HCGS) _____	
Monospot (Infectious Mono)(MS) _____		<input type="checkbox"/> Urine <input type="checkbox"/> Serum	
Trichomonas Antigen (TVA) _____ (where applicable)		PV Semen (PVSA) _____	

Bio-Chemistry

Cardiac Marker (i-STAT)

TEST	RESULT	REFERENCE RANGE	Units
<input type="checkbox"/> Glucose (G) <input type="checkbox"/> Chloride (CL)		L Troponin I (TROP) _____	0.00 - 0.08 ug/L
<input type="checkbox"/> Urea (BUN) (U)			
<input type="checkbox"/> Sodium (NA)			
<input type="checkbox"/> Potassium (K)			
<input type="checkbox"/> Creatinine (CR)			
<input type="checkbox"/> Lipase (LIPA)			
<input type="checkbox"/> Total Bilirubin (TBIL)			
<input type="checkbox"/> CK (where applicable)(CK)			
<input type="checkbox"/> LDH (where applicable)(LDH)			
Oral Glucose Tolerance Testing			
<input type="checkbox"/> 50 Gram 1 hour screen (GT50)			
<input type="checkbox"/> 75 Gram Non-gestational (GTT2)			
<input type="checkbox"/> 75 Gram Gestational (GTTP)			
	RESULT		
Fasting glucose	_____		
1 hour glucose	_____		
2 hour glucose	_____		
Note: For Oral Glucose Reference Ranges, please use Canadian Diabetes Association Clinical Practice Guidelines			
		TEST	RESULT
		L Feces Occult Blood (OB)	
		Sample #1	Negative _____
		Sample #2	Negative _____
		Sample #3	Negative _____

Technologist Initials: _____ Date: _____ Time: _____