

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.

### MISCELLANEOUS TEST REPORT

ORDERING PROVIDER INFORMATION				PATIENT INFORMATION			
* LAST AND FULL FIRST NAME:		BILLING CODE:		* LAST/FIRST NAME: (AS PER MANITOBA HEALTH CARD)			
* ORDERING FACILITY:		INPATIENT LOCATION:		* DATE OF BIRTH: (DD/MM/YYYY)			
ADDRESS:				* SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE			
* PHYSICIAN CRITICAL RESULTS PHONE NO:		* FAX NO:		* PHIN			
ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #1				* ALTERNATE ID (INCLUDE ID TYPE WITH NUMBER, IE: RCMP, SK, DND, ETC)			
* LAST AND FULL FIRST NAME:		BILLING CODE:		MRN:			
* FACILITY NAME:				ENCOUNTER NUMBER:			
ADDRESS:				* PATIENT PHONE NO: DEMOGRAPHICS VERIFIED WITH: <input type="checkbox"/> PROVINCIAL HEALTH CARD <input type="checkbox"/> ARMBAND <input type="checkbox"/> ECHART/CR			
PHONE NO:		* FAX NO:		ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #2			
* LAST AND FULL FIRST NAME:		BILLING CODE:		HISTORY:		* COLLECTION D/T: (DD/MM/YYYY)	
* FACILITY NAME:						* COLLECTION FACILITY/LAB:	
ADDRESS:				<input type="checkbox"/> CLINIC <input type="checkbox"/> ER <input type="checkbox"/> IP			
PHONE NO:		* FAX NO:					
<input type="checkbox"/> CBC: SEE SEPARATE REPORT							
HEMATOLOGY							
TEST	RESULT	UNITS	REFERENCE RANGE			INITIALS:	DATE:
<input type="checkbox"/> ESR		mm/HR mm /HR mm /HR	0 – 15 MALE 0 – 20 FEMALE 0 – 10 M/F < 17 YEARS OLD				
HEMATOLOGY							
TEST	RESULT	UNITS	REFERENCE RANGE			INITIALS:	DATE:
<input type="checkbox"/> PT <input type="checkbox"/> INR		SECONDS	10.1 – 12.8 0.9 - 1.1	<input type="checkbox"/> PERFORMED BY POCT DEVICE <input type="checkbox"/> COMMENT: ATTENTION: PRELIMINARY REPORT. SAMPLE IS REFERRED FOR CONFIRMATION. FINAL REPORT TO FOLLOW.			
MICROBIOLOGY							
TEST				RESULT		INITIALS:	DATE:
<input type="checkbox"/> THROAT SWAB GROUP A STREPTOCOCCAL ANTIGEN				<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE			
<b>NOTE:</b> NEGATIVE STREPTOCOCCAL ANTIGEN TESTS FROM PATIENTS LESS THAN 18 YEARS OF AGE: IF CLINICAL SYMPTOMS ARE SUGGESTIVE OF STREPTOCOCCAL PHARYNGITIS, A FOLLOW UP THROAT SWAB SHOULD BE SUBMITTED TO THE LAB FOR CULTURE. POSITIVE STREPTOCOCCAL ANTIGEN TESTS: IF PATIENT HAS A PENICILLIN ALLERGY (AND A SWAB FOR CULTURE WAS SUBMITTED), PLEASE NOTIFY LAB IMMEDIATELY SO ANTIMICROBIAL SUSCEPTIBILITY TESTING FOR ALTERNATE AGENTS CAN BE PERFORMED. IF SWAB FOR CULTURE NOT SUBMITTED, PLEASE COLLECT AND SUBMIT TO LAB FOR SUSCEPTIBILITY TESTING; INDICATE PATIENT IS PENICILLIN ALLERGIC.							
<input type="checkbox"/> INFECTIOUS MONONUCLEOSIS TEST				<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		INITIALS:	DATE:
CHEMISTRY							
TEST	RESULT		COMMENT		INITIALS:	DATE:	
<input type="checkbox"/> PREGNANCY TEST	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE						
<input type="checkbox"/> FECAL OCCULT BLOOD					INITIALS:	DATE:	
<input type="checkbox"/> SAMPLE 1	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE						
<input type="checkbox"/> SAMPLE 2	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE						
<input type="checkbox"/> SAMPLE 3	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE						
<input type="checkbox"/> NOT PERFORMED					INITIALS:	DATE:	