AS PER DSM SPECIMEN ACCEPTANCE POLICY, 10-50-03, REQUIREMENTS FOR TEST REQUISITIONS 2.1, ALL INFORMATION MARKED WITH AN ASTERISK * IS MANDATORY AND MUST BE CLEARLY LEGIBLE. FAILURE TO COMPLY MAY RESULT IN SPECIMEN REJECTION.

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 ☐ FEMALE ☐ MALE
*PHYSICIAN CRITICAL RESULTS PHONE NO:		* FAX NO.		* PHIN
				* ALTERNATE ID (INCLUDE ID TYPE WITH NUMBER, IE: RCMP, SK, DND, ETC)
ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #1				
* LAST AND FULL FIRST NAME:		BILLING CODE:		MRN:
* FACILITY NAME:				ENCOUNTER NUMBER:
ADDRESS:				* PATIENT PHONE NO: DEMOGRAPHICS VERIFIED WITH: ☐ PROVINCIAL HEALTH CARD ☐ ARMBAND ☐ ECHART/CR
PHONE NO:		* FAX NO:		
ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #2				**COLLECTION INFORMATION**
* LAST AND FULL FIRST NAME:		BILLING CODE:		HISTORY: / * COLLECTION D/T: (DD/MM/YYYY)
* FACILITY NAME:				
ADDRESS:				* COLLECTION FACILITY/LAB:
PHONE NO:		* FAX NO:		☐ CLINIC ☐ ER ☐ IP

☐ **CBC**: SEE SEPARATE REPORT

HEMATOLOGY

TEST	RESULT	UNITS	REFERENCE RANGE
☐ **ESR**		mm/HR	0 – 15 MALE
		mm /HR	0 – 20 FEMALE
		mm /HR	0 – 10 M/F < 17 YEARS OLD

INITIALS: DATE:

HEMATOLOGY

TEST	RESULT	UNITS	REFERENCE RANGE	
☐ **PT**		SECONDS	10.1 – 12.8	☐ PERFORMED BY POCT DEVICE
☐ **INR**			0.9 - 1.1	☐ COMMENT: ATTENTION: PRELIMINARY REPORT. SAMPLE IS REFERRED FOR CONFIRMATION. FINAL REPORT TO FOLLOW.

INITIALS: DATE:

MICROBIOLOGY

TEST	RESULT	
☐ **THROAT SWAB GROUP A STREPTOCOCCAL ANTIGEN**	☐ POSITIVE	☐ NEGATIVE

NOTE: **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.

INITIALS: DATE:

☐ **INFECTIOUS MONONUCLEOSIS TEST** ☐ POSITIVE ☐ NEGATIVE

INITIALS: DATE:

CHEMISTRY

TEST	RESULT		COMMENT
☐ **PREGNANCY TEST**	☐ POSITIVE	☐ NEGATIVE	

INITIALS: DATE:

☐ **FECAL OCCULT BLOOD**

☐ SAMPLE 1	☐ POSITIVE	☐ NEGATIVE
☐ SAMPLE 2	☐ POSITIVE	☐ NEGATIVE
☐ SAMPLE 3	☐ POSITIVE	☐ NEGATIVE
☐ NOT PERFORMED		

INITIALS: DATE: