



General Chemistry and Hematology Requisition

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As per DSM Acceptance Policy 10-50-03 - Requirements for Test Requisitions 2.1 - All information marked with an * is mandatory and must be clearly legible. Failure to comply may result in specimen rejection.

COLLECTION INFORMATION	PATIENT INFORMATION
<p>All dates and times must be in dd/mm/yy and hh/mm format</p> <p>Scheduled Collection Date: _____ Time: _____</p> <p>Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Stat Fasting <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>TDM Collection: Last dose date: _____ Time: _____ Next dose date: _____ Time: _____</p> <p>*Collection Date: _____ *Collection Time: _____</p> <p>* Collector: _____</p> <p>Collected via: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary Additional Collection Considerations: <input type="checkbox"/> Above IV shut off <input type="checkbox"/> Below IV shut off <input type="checkbox"/> By unit <input type="checkbox"/> From PIC/Central Line/Art line</p> <p>Referring Lab: Number of tubes sent _____ Check if samples shipped frozen <input type="checkbox"/> EDTA ___ SST (gel) ___ PST (gel) ___ Serum (no gel) ___ Citrate ___</p> <p>Copy of report to Lab: <input type="checkbox"/> YES <input type="checkbox"/> NO *Collection Facility/Lab: _____</p>	<p>*Last/First Name: _____ (As per MB. Health Card)</p> <p>* Date of Birth (dd/mm/yyyy) *Sex: Female Male *PHIN: _____</p> <p>*Alternate ID: (include ID type with number ie RCMP, SK, DND) MRN: _____ Encounter Number: _____</p> <p>Demographics verified with: <input type="checkbox"/> Provincial Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Third Party verbal - Name and Contact Info: _____</p> <p>*Patient Phone No: _____ *Patient address: _____</p>

ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	ORDERING PROVIDER INFORMATION
<p>*Providers Full last and first name: _____</p> <p>*Facility name: _____ *Fax #: _____</p>	<p>*Last & Full First Name: _____ *Billing Code: _____ *Ordering Inpatient Facility: _____ Location: _____ Address: _____</p> <p>*Critical Results Phone Number: _____ *Fax Number: _____</p>

CHEMISTRY		
SODIUM	NAR	
POTASSIUM	KR	
CHLORIDE	CLR	
CARBON DIOXIDE-TOTAL	CO2	
GLUCOSE <input type="checkbox"/> F <input type="checkbox"/> R	G	
UREA	U	
CREATININE	CR	
CALCIUM/CORRECTED CALCIUM	CA	
PHOSPHATE	P	
MAGNESIUM	MG	
URIC ACID	UA	
LIPASE	LIPA	
CREATINE KINASE	CK	
LACTATE DEHYDROGENASE	LDH	
ALKALINE PHOSPHATASE	ALKP	
ALANINE TRANSAMINASE	ALTR	
ASPARTATE TRANSAMINASE	ASTR	
TOTAL BILIRUBIN	TB	
DIRECT BILIRUBIN	DB	
GAMMA GLUTAMYL TRANSFERASE	GGT	
ALBUMIN	AL	
TOTAL PROTEIN	TP	
CRP	CRP	
HS TROPONIN T	HTNT	
HCG-Chorionic Gonadotropin	HCGQ	
OSMOLALITY (Serum)	OS	

HEMATOLOGY		
CBC		CBC
RETIC COUNT		RETA
ESR		ESR
INFECTIOUS MONO		MS
INR		PT
APTT		APTT
Heparin Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
BLOOD GASES		
ARTERIAL		AGAS
VENOUS		VGAS
CAPILLARY		CGAS
CORD ARTERIAL		UAGS
CORD VENOUS		UVGS
ARTERIAL LACTATE		ILCA
VENOUS LACTATE		ILCV
CSF		
GLUCOSE		GLC
PROTEIN		PC
CELL COUNT & DIFFERENTIAL		CSFH

FLUIDS		
FLUID TYPE:		
CELL COUNT & DIFFERENTIAL		HFLD
CRYSTALS		CRYS

MISCELLANEOUS		
GRP A STREP ANTIGEN		SATA
FETAL FIBRONECTIN		FFN
FECAL OCCULT BLOOD		OB
SEMEN ANALYSIS (Fertility)		SFT
POST VASECTOMY SEMEN		PVSA

GLUCOSE TOLERANCE TESTING		
50 Gram Challenge		GT50
75 gm Tolerance-Preg Fast;1hr;2hr		GTPP
75 gm Tolerance-Non-Preg Fast;2hr		GTT2

DRUG LEVELS **Enter Dosage Times at Top**		
SALICYLATES **		SAL
ACETAMINOPHEN **		ACTM
ALCOHOL		ETO
LITHIUM **		LI
GENTAMICIN ** <input type="checkbox"/> TROUGH <input type="checkbox"/> PEAK		GENT
VANCOMYCIN ** <input type="checkbox"/> TROUGH <input type="checkbox"/> PEAK		VANC
TOBRAMYCIN ** <input type="checkbox"/> TROUGH <input type="checkbox"/> PEAK		TOBR
CARBMAZAPINE (Tegretol)**		CARB
PHENOBARBITOL**		PHEN
PHENYTOIN/DILANTIN**		PYN
VALPROIC ACID **		VALP
DIGOXIN**		DIG
THEOPHYLLINE**		TEO
FK506 TACROLIMIS **		FK5
SIROLIMUS **		SIRO
CYCLOSPORIN **		CY

REFERRALS		
ESTRADIOL		E2
PROGESTERONE		PGN
FSH-FOLLICLE STIMULATING HORMONE		FSH
LH-LUTEINIZING HORMONE		LH
PROLACTIN		PL
IgE-IMMUNOGLOBULIN E		IGE
CORTISOL <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Random		COR
PROGESTERONE		PGN
CARCINOEMBRYONIC ANTIGEN		CEA
ALPHA-FETOPROTEIN		AFP
CA19-9		CA19
CA125		CA12
CA15-3		CA15
DHEAS		DHAS
FREE ANDROGEN INDEX		FAI
THYROPEROXIDASE ANTIBODIES		TPO
GROWTH HORMONE		GH
ANGIOTENSIN CONV. ENZYME		ACE
RENIN (EDTA)		REN
ALDOSTERONE		ALDO
17-HYDROXYPROGESTERONE		PR17
PTH		PTH

URINE		
TYPE OF URINE COLLECTION: <input type="checkbox"/> RANDOM <input type="checkbox"/> 24 H <input type="checkbox"/> 12HR		
Start Date/Time: _____		
End Date/Time: _____		
HEIGHT: (cm) _____		
WEIGHT: (kg) _____		
VOLUME: (mL) _____		
OSMOLALITY		OSU
SODIUM		NAUR
POTASSIUM		KUR
CREATININE		CRU
UREA		UU
TOTAL PROTEIN		TPU
URINE ALBUMIN		UALB
CREATININE CLEARANCE		CRCL
URINE DRUG SCREEN		DAUW
Specify Drugs: <input type="checkbox"/> Ethanol <input type="checkbox"/> Amphetamine <input type="checkbox"/> Barbiturate		
<input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Cocaine metabolite <input type="checkbox"/> Methadone		
<input type="checkbox"/> Cannabinoids <input type="checkbox"/> Opiates <input type="checkbox"/> Oxycodone <input type="checkbox"/> Urine Tricyclic		
URINALYSIS		UR
URINE PREGNANCY TEST		PREG
Hgb A1C (EDTA)		GYHB
ACTH (EDTA)		ACTH
AMMONIA (EDTA)		AMM
D-DIMER (CITRATE)		DDIM
CELIAC DISEASE SCREEN		GLUG
TISSUE TRANSGLUTAMINASE		TTG
ANA SCREEN		ANA
IgG		IGG
IgA		IGA
IgM		IGM
COMPLEMENT C3		C3
COMPLEMENT C4		C4
RHEUMATOID FACTOR		RF
CYCLIC CITRULLINATED PEPTIDE		CCP
SSA/Ro/JO-1/SSB/SCL/RNP		ENA
SMOOTH MUSCLE ANTIBODY		SMA