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.

Adrenal Vein Sampling

DIAGNOSTIC SERVICES MANITOBA SERVICES DIAGNOSTICS MANITOBA

*As per DSM Acceptance Policy 10-5--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.*

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION
*Last & Full First Name:	Billing Code:	*Last/First Name: (As per MB. Health Card)
*Ordering Facility:	Inpatient Location:	* Date of Birth (dd/mm/yyyy)
Address:		*Sex: Female Male
*Critical Results Phone Number:	*Fax Number:	*PHIN:
COLLECTION INFORMATION		*Alternate ID: (include ID type with number ie RCMP, SK, DND)
Copy of report to Lab ❑ YES ❑ NO		MRN:
*Collection Facility/Lab:		Encounter Number:
Collection Date:		Demographics verified with: ❑ Provincial Health Card ❑ Armband ❑ eChart/C
Collection Time:		*Patient Phone No:
Collected by (Last Name, First name):		*Patient Address:

ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION		ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	
*Last & Full First Name:	Billing Code:	*Last & Full First Name:	Billing Code:
*Ordering Facility:	Inpatient Location:	*Ordering Facility:	Inpatient Location:
Address:		Address:	
*Critical Results Phone Number:	*Fax Number:	*Critical Results Phone Number:	*Fax Number:

Anatomic Location (please indicate with a check mark):

1. **Fill out one requisition for each tube of blood (Red Top, Serum) collected for each anatomic location and labelled as RAV, LAV or IVC and patient identifier. Thus, one tube for both Aldosterone and Cortisol.**

□ Right Adrenal Vein, RAV

Test	Delphic Code	Mayo Code
Aldosterone, right adrenal vein	MISC	ARAV
Cortisol, right adrenal vein	MISC	CRAV

□ Left Adrenal Vein, LAV

Test	Delphic Code	Mayo Code
Aldosterone, left adrenal vein	MISC	ALAV
Cortisol, left adrenal vein	MISC	CLAV

□ External Iliac Vein, IVC

Test	Delphic Code	Mayo Code
Aldosterone, Inferior vena cava	MISC	AIVC
Cortisol, Inferior vena cava	MISC	CIVC