



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	
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	

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	

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	
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	
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)		
SODIUM	NAUR	
POTASSIUM	KUR	
CREATININE	CRU	
UREA	UU	
TOTAL PROTEIN	TPU	
URINE ALBUMIN	UALB	
CREATININE CLEARANCE	CRCL	
URINE DRUG SCREEN	DAUW	
<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	
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	

REFERRALS		
Cholesterol (Total) <input type="checkbox"/> F <input type="checkbox"/> R	CH	
Cholesterol (HDL) <input type="checkbox"/> F <input type="checkbox"/> R	LIPP	
Aspartate Transaminase	AST	
Triglyceride <input type="checkbox"/> F <input type="checkbox"/> R	TG	
IRON	IRON	
TIBC	TIBC	
FERRITIN	FER	
VITAMIN B12	B12	
TSH	TSH	
FREE T4	FT4	
FREE T3	FT3	
PSA	PRSA	

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	GTTP	
75 gm Tolerance-Non-Preg Fast;2hr	GTT2	