

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.

BODY FLUID REQUISITION

LAB USE ONLY
BARCODE

Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection

Ordering Provider Information			Patient Information (print or use addressograph)		
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)		
*Facility Name / Address:			* Date of Birth (dd/mm/yyyy)		
Critical Results Ph #:		Fax #:	*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
		Ph #:	*PHIN: Specify if other province/ DND		
Copy Report To (if info missing, report may not be sent):			MRN:		
Last & Full First Name:	Ph #:	Fax #:	Encounter#:		
Facility Name/ Address:			Patient Phone #:		
Last & Full First Name:			Patient Address:		
Ph #:			Demographics verified via:		
Fax #:			<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other		
Facility Name/ Address:					
COLLECTION INFORMATION (Fields marked with ♦ required by person collecting sample)					
♦ Collector:			♦ Collection Date:		
♦ Collection Facility/Lab:			♦ Time:		
Check off FLUID TYPE & the TEST(s) requested (**All requests for cell count & differential require additional sample)					
*Indicates tests that <u>require</u> the same test ordered on a matching blood sample. For Fluid Triglyceride orders, the blood must be drawn within 2 hours of fluid collection. For the other tests it must be drawn within 6 hours – on separate requisition.					
<input type="checkbox"/> PLEURAL FLUID (Thoracentesis)	PR	<input type="checkbox"/> PERITONEAL FLUID (Ascites)	PT	<input type="checkbox"/> Other Fluid (specify site): _____	
<input type="checkbox"/> Total Protein *	TPFL	<input type="checkbox"/> Total Protein *	TPFL	<input type="checkbox"/> **Cell Count & Differential HFLD	
<input type="checkbox"/> LD *	LDLFL	<input type="checkbox"/> Albumin *	ALFL	<input type="checkbox"/> Crystals CRYL	
<input type="checkbox"/> Glucose	GFL	<input type="checkbox"/> Triglyceride *	TGFL	<input type="checkbox"/> Fluid for Eosinophils FFE	
<input type="checkbox"/> Creatinine	CRFL	<input type="checkbox"/> LD *	LDLFL	<input type="checkbox"/> Other tests (specify): _____	
<input type="checkbox"/> Cholesterol	CHFL	<input type="checkbox"/> Glucose*	GFL	Might require blood or urine samples; contact laboratory for consult	
<input type="checkbox"/> Triglyceride	TGFL	<input type="checkbox"/> Creatinine	CRFL	<input type="checkbox"/> CEREBROSPINAL FLUID	
<input type="checkbox"/> Lipase	LPFL	<input type="checkbox"/> Bilirubin*	BFL	<input type="checkbox"/> Protein PC	
<input type="checkbox"/> **Cell Count & Differential	HFLD	<input type="checkbox"/> Lipase*	LPFL	<input type="checkbox"/> Glucose *Must be sent on ice* GLC	
<input type="checkbox"/> SYNOVIAL FLUID	SY	<input type="checkbox"/> **Cell Count & Differential	HFLD	<input type="checkbox"/> Lactate *Must be sent on ice* SFLA	
<input type="checkbox"/> Total Protein	TPFL	<input type="checkbox"/> DIALYSIS FLUID	DF	<input type="checkbox"/> Chloride CLC	
<input type="checkbox"/> LD	LDLFL	<input type="checkbox"/> Sodium	NAFL	<input type="checkbox"/> **Cell Count & Differential CSFH	
<input type="checkbox"/> Glucose	GFL	<input type="checkbox"/> Potassium	KFL	<input type="checkbox"/> Suspected New or Relapsed CSFP	
<input type="checkbox"/> Uric Acid	UAFL	<input type="checkbox"/> Glucose	GFL	Leukemia	
<input type="checkbox"/> Lactic Acid	LAFL	<input type="checkbox"/> Urea	UFL	<input type="checkbox"/> Protein Electrophoresis* SFPE	
<input type="checkbox"/> Cholesterol*	CHFL	<input type="checkbox"/> Creatinine	CRFL	Oligoclonal Bands (Blood sample required)	
<input type="checkbox"/> Triglyceride*	TGFL	<input type="checkbox"/> Phosphate	PFL	<input type="checkbox"/> LIQUID STOOL LS	
<input type="checkbox"/> **Cell Count & Differential	HFLD	<input type="checkbox"/> Total Protein	TPFL	<input type="checkbox"/> Sodium NAFL	
<input type="checkbox"/> Crystals	CRYL	<input type="checkbox"/> **Cell Count & Differential	HFLD	<input type="checkbox"/> Potassium KFL	
<input type="checkbox"/> PERICARDIAL FLUID	PC	<input type="checkbox"/> BRONCHOALVEOLAR LAVAGE	BAL	<input type="checkbox"/> Osmolality MSFL	
<input type="checkbox"/> Total Protein *	TPFL	<input type="checkbox"/> Differential	HFLD	<input type="checkbox"/> Chloride MSFL	
<input type="checkbox"/> Albumin *	ALFL	<input type="checkbox"/> SEMEN ANALYSIS		<input type="checkbox"/> STOOL	
<input type="checkbox"/> LD *	LDLFL	<input type="checkbox"/> Fertility Testing	SFT	<input type="checkbox"/> Fecal Fat (Natural & Split) - FECA	
<input type="checkbox"/> Triglyceride*	TGFL	<input type="checkbox"/> Post Vasectomy	PVSA	Qualitative	
<input type="checkbox"/> CEA	CEFL				
<input type="checkbox"/> **Cell Count & Differential	HFLD				
<input type="checkbox"/> PANCREATIC FLUID	PA				
<input type="checkbox"/> CEA	CEFL				
<input type="checkbox"/> CA19-9	C19F				