

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.

Molecular Diagnostic Laboratory Requisition

Please have all specimens delivered to:
Health Sciences Centre-Central Services
MS551- 820 Sherbrook St
Winnipeg, Manitoba R3A 1R9

For specimen requirements and test information contact:
MDL Telephone: 204-787-1024
Lab Fax: 204-787-3846
Call Centre (24 hr): 204-787-1534
SHIP SAMPLES AT ROOM TEMPERATURE

Additional requisitions and sample requirements available at:
www.dsmanitoba.ca /Medical Practitioners / LIM

* Fields marked with an asterisk are mandatory and must be clearly legible. Failure to comply may result in specimen rejection (see DSM policy 10-50-03).

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION	
*Last & Full First Name:	Billing Code:	*Last/First Name: (as per Manitoba Health Card)	
*Ordering Facility:	Inpatient Location:	*Date of Birth: (dd/mm/yyyy)	Address:
Address:		*Biological Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
*Critical Results Phone No:	*Fax No.	*PHIN:	
ADDITIONAL COPY OF REPORT (FOR MANITOBA PHYSICIANS ONLY)		*Alternate ID: (include ID type with number i.e. RCMP, SK, DND, etc.)	*Phone No:
*Last & Full First Name:	Billing Code:		
*Facility Name:		MHSC#:	MRN:
Address:		Encounter Number:	
Phone No:	*Fax No.	Demographics verified with:	<input type="checkbox"/> Health Card <input type="checkbox"/> eChart/CR <input type="checkbox"/> Armband
CONTACT INFO		COLLECTION INFORMATION	
Clinic/Laboratory Contact Name:	*Collector:	*Collection Time: (hh:mm)	
Clinic/Laboratory Contact Telephone No.:	*Collection Date: (dd/mm/yyyy)	*Collection Facility/Lab:	
I. Test Requested See website for test details, guidelines and sample requirements https://apps.sbgq.mb.ca/labmanual/		II. Reason for Test May require prior genetic consultation before testing.	
<input type="checkbox"/> Angelman Syndrome MD <input type="checkbox"/> APOE MD <input type="checkbox"/> Ashkenazi Jewish Panel (ASPA, HEXA, IKBKAP, FANCC) MD <input type="checkbox"/> Charcot-Marie-Tooth type 1A MD <input type="checkbox"/> Cystic Fibrosis/ CFTR-related disorders (ethnic background required) MD <input type="checkbox"/> DNA banking MD <input type="checkbox"/> Familial Hypertrophic Cardiomyopathy(Mennonite mutation)MD <input type="checkbox"/> Fragile X/ FMR1- related disorders MD <input type="checkbox"/> Hemochromatosis (transferrin saturation required) MD <input type="checkbox"/> Hereditary Neuropathy with Liability to Pressure Palsies MD <input type="checkbox"/> HNF1α (Aboriginal mutation) MD <input type="checkbox"/> Huntington disease MD <input type="checkbox"/> Hypophosphatasia (Mennonite mutation) MD <input type="checkbox"/> Kennedy disease MD <input type="checkbox"/> Myotonic Dystrophy Type 1(ethnic background required) MD <input type="checkbox"/> Non-Syndromic Deafness (GJB2 and GJB6) (ethnic background required) MD <input type="checkbox"/> Oculopharyngeal Muscular Dystrophy MD <input type="checkbox"/> Prader-Willi Syndrome MD <input type="checkbox"/> Spinal Muscular Atrophy (referred out) MD <input type="checkbox"/> Spinocerebellar ataxia types 1,2,3,6,7,8 MD <input type="checkbox"/> Thalassemia (ethnic background required) MD <input type="checkbox"/> Yq microdeletion MD <input type="checkbox"/> Other (includes referred out testing) MD		<input type="checkbox"/> Blood 2x 4 mL EDTA <input type="checkbox"/> Blood (infant only) 0.5-2 mL EDTA <input type="checkbox"/> DNA 15 µg Minimum concentration 150ng/µL For other Sample Types: <input type="checkbox"/> Cultured Amniocytes ◇ <input type="checkbox"/> Amniotic Fluid ◇ 4-10 mL <input type="checkbox"/> Tissue Pathology Reference No. _____ <input type="checkbox"/> Other _____ ◇ Contact lab prior to ordering. Sample volumes may vary.	
		III. Clinical Information and Family History Testing will NOT be initiated without this information. Please provide pedigree and ethnicity	
		Is this patient or patient's partner pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes LMP: _____ <input type="checkbox"/> Confirmation of Clinical Diagnosis <input type="checkbox"/> Carrier Status <input type="checkbox"/> Predictive Testing <input type="checkbox"/> Prenatal Diagnosis (maternal blood required) Contact Lab prior to ordering	
		Other family members tested previously: <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____ Relationship to Patient: _____	

Delphic Barcode Label