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.

Shared Health HAEMOSTASIS CONSULT

Requesting Physician Information:

Name: _____

Address: _____

_____

Phone: (204) _____

FAX: (204) _____

Patient Demographics: (please fill in or use addressograph):

Name:

DOB:

PHIN/MHSC:

Gender:

Address:

Phone (day):

Phone (evening):

PATIENT CLINICAL HISTORY (attach documents as required):

Current Clinical: _____

Thrombosis/Bleeding: _____

Family: _____

Autoimmune Disorders: _____

Medications: _____

REQUESTED PHLEBOTOMY SITE: ☐ **WL** ☐ **HSC** ☐ **Other** _____ **FAX #** _____

REQUESTED TESTS:

- ☐ BLEEDING DISORDER INVESTIGATION: _____
- ☐ HYPERCOAGULABILITY STUDIES: _____
- ☐ OTHER: _____

FOR LAB USE ONLY

Hematopathologist Instructions: ☐ **Proceed with testing as specified below** ☐ **Cancelled**

Comments/Direction: _____

_____

_____ _____ _____

Hematopathologist Name (please print) Signature Date

TO BE COMPLETED BY HSC:

Faxed to Physician: Date: _____ Time: _____ Tech: _____

Faxed to Rural site: Date: _____ Time: _____ Tech: _____

Specimen received in Lab: Date: _____ Time: _____ Tech: _____

TO BE COMPLETED BY REQUESTING SITE:

Phlebotomy appointment booked for: Date: _____ Time: _____ Tech: _____

IMPORTANT

INSTRUCTIONS:

Policy: Haemostasis testing must be requested through a Shared Health Hematopathologist (or initiated by Clinical Hematologist consult) to ensure appropriate service.

Procedure:

- **The requesting physician must complete this consult form** fully with all requested information (including all patient and physician information and contact numbers). Incomplete forms will not be accepted.
- Once completed, the form is faxed to HSC Hematopathology 204-787-4030, ATTENTION: Hematopathologist on service or on-call for Haemostasis
- The HSC Hematopathology Office will contact the requesting physician, faxing back the form with the status of the request, to the physician.
- **Ordering physician will complete Hemostasis Requisition (R250-10-12)** selecting the approved tests, fill the required patient, physician and contact information, and copy the approved consult form, to give to the patient
- Patient will attend approved phlebotomy site with **requisition and approved consult form for collection**.
- An interpretive report will be sent to the requesting physician once testing is complete.