

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.

<b>Requesting Physician Information:</b> <b>Name:</b> _____ <b>Address:</b> _____ _____ <b>Phone: (204)</b> _____ <b>FAX: (204)</b> _____	<b>Patient Demographics: (please fill in or use addressograph):</b> <b>Name:</b> _____ <b>DOB:</b> _____ <b>PHIN/MHSC:</b> _____ <b>Gender:</b> _____ <b>Address:</b> _____ <b>Phone (day):</b> _____ <b>Phone (evening):</b> _____
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**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: \_\_\_\_\_

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**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.