

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.

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: <input type="checkbox"/> WL <input type="checkbox"/> HSC <input type="checkbox"/> Other _____ FAX # _____ REQUESTED TESTS: <input type="checkbox"/> BLEEDING DISORDER INVESTIGATION: _____ <input type="checkbox"/> HYPERCOAGULABILITY STUDIES: _____ <input type="checkbox"/> OTHER: _____	
Hematopathologist Instructions: <input type="checkbox"/> Proceed with testing as specified below <input type="checkbox"/> Cancelled Comments/Direction: _____ _____ _____ <div style="display: flex; justify-content: space-between; margin-top: 10px;"> Hematopathologist Name (please print) Signature Date </div>	
TO BE COMPLETED BY HSC: <div style="display: flex; justify-content: space-between;"> Faxed to Physician: Date: _____ Time: _____ Tech: _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Faxed to Rural site: Date: _____ Time: _____ Tech: _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Specimen received in Lab: Date: _____ Time: _____ Tech: _____ </div>	
TO BE COMPLETED BY REQUESTING SITE: <div style="display: flex; justify-content: space-between;"> Phlebotomy appointment booked for: Date: _____ Time: _____ Tech: _____ </div>	
INSTRUCTIONS: Policy: Haemostasis testing must be requested through a Shared Health Hematopathologist (or initiated by Clinical Hematologist consult) to ensure appropriate service. Procedure: <ul style="list-style-type: none"> 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. 	

FOR LAB USE ONLY

IMPORTANT