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.

DIAGNOSTIC SERVICES MANITOBA | SERVICES DIAGNOSTICS MANITOBA

Vitamin D (25-Hydroxy) Requisition

As per DSM Specimen Acceptance Policy 10-50-03 – Requirements for Test Requisitions 2.1 - All information marked with an asterisk * is mandatory and must be clearly legible. Failure to comply may result in specimen rejection.

ORDERING PROVIDER INFORMATION			
*Last &Full First Name:		Billing Code:	
*Ordering Facility :		Inpatient Location:	
Address:			
Physician Critical Results Phone No:			
*Phone No:		* Fax No.	

ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #1			
*Last &Full First Name:		Billing Code:	
*Facility Name:			
Address:			
Phone No:		* Fax No.	

ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #2			
*Last &Full First Name:		Billing Code:	
*Facility Name:			
Address:			
Phone No:		* Fax No.	

PATIENT INFORMATION
*Last/First Name: (As per Manitoba Health Card)
*Date of Birth (dd/mm/yyyy):
*Sex: ☐ Female ☐ Male
*PHIN:
*Alternate ID: (include ID type with number ie: RCMP, SK, DND etc) MRN:
Encounter Number:
Patient Phone No:
Demographics verified with: ☐ Provincial Health Card ☐ Armband ☐ eChart/CR

COLLECTION INFORMATION			
*Collector:		*Collection D/T: (dd/mm/yyyy)	
Circle for copy of report to referal lab	YES	*Collection Facility:	
Collected Via: ☐ Venipuncture ☐ Capillary ☐ Indwelling Line ☐ Above Shut Off IV			
Referring Lab: Number of tubes sent: Serum (no gel) _____		Circle if Samples shipped frozen	

☐ Vitamin D (25 Hydroxy) - VD25

All medically necessary 25-hydroxy vitamin D testing will be supported by DSM. 25-hydroxy vitamin D testing that does not meet at least one of the testing criteria listed below will be deemed not medically necessary, and will not be performed.

Check all criteria that apply to this patient:

- ☐ Metabolic bone disease (recurrent fractures, rickets, osteomalacia, osteopenia, osteoporosis)
- ☐ Abnormal blood calcium, magnesium or phosphate concentrations
- ☐ Parathyroid disease
- ☐ Malabsorption syndromes (celiac disease, small intestine surgery, Cystic Fibrosis, or medications that may interfere with vitamin D absorption cholestyramine, orlistat etc)
- ☐ Anticonvulsant agents
- ☐ Chronic renal disease
- ☐ Chronic liver disease
- ☐ Intake of high dose vitamin D combined with symptoms suggesting hypervitaminosis D

REQUIRED - Signature of Ordering Professional:_____

Sample will not be collected if this requisition has not been signed by the ordering professional.