

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.

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				PATIENT INFORMATION			
* Last & Full First Name:		Billing Code:		* Last/First Name: (As per Manitoba Health Card)			
* Ordering Facility Address:		Inpatient Location:		* Date of Birth (dd/mm/yyyy):			
Physician Critical Results Phone No:				* Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male			
* Phone No:		* Fax No.		* PHIN:			
ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #1				* Alternate ID: (include ID type with number ie: RCMP, SK, DND etc)			
* Last & Full First Name:		Billing Code:		MRN:			
* Facility Name:				Encounter Number:			
Address:				Patient Phone No:			
Phone No:		* Fax No.		Demographics verified with: <input type="checkbox"/> Provincial Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR			
ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION - #2				COLLECTION INFORMATION			
* Last & Full First Name:		Billing Code:		* Collector:		* Collection D/T: (dd/mm/yyyy)	
* Facility Name:				Circle for copy of report to referral lab	YES	* Collection Facility:	
Address:				Collected Via: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line <input type="checkbox"/> Above Shut Off IV			
Phone No:		* Fax No.		Referring Lab: Number of tubes sent: _____	Circle if Samples shipped frozen		
				Serum (no gel) _____			

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.