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.

Ship samples to:
St/ Boniface Hospital Hematology Lab
L4006-409 Tache Ave
Winnipeg, MB R2H 2A6
Phone: 204-237-2468
Fax: 204-237-2494

HIT Screen
Heparin Induced Thrombocytopenia
Screening Requisition

This space for lab use only
Place DELPHIC Label here

Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection.

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION
***Last & Full First Name:**		*Last/First Name: (per MB Health Card)
Billing Code:	**Inpatient Location:**	* Date of Birth (dd/mm/yyyy)
***Facility Name/Address**		*Sex: Female Male
Phone No:	**Fax No:**	*PHIN:
Critical Results Phone Number:		*Specify Province or DND if different
COPY REPORT TO: (if info missing, report may not be sent)		MRN:
Last & Full First Name:	**Fax No:**	Encounter Number:
Facility Name/Address:	**Phone No:**	Patient Phone Number:
Last & Full First Name:	**Fax No:**	Patient Address:
Facility Name/Address:	**Phone No:**	Demographics verified: ❑ Health Card ❑ Armband ❑ eChart/CR ❑ Other
Collection Information Fields marked with "♦"required by person collecting sample		
♦Collector:	**♦Collection Date:**	♦Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Above shut off IV
♦Collection Facility/Lab:	**♦Collection Time:**	
# Serum vial(s) ____ # Plasma vials(p) ____	Referring Lab: # of tubes sent ____	Samples shipped frozen ❑

****** Testing WILL NOT be initiated if the section BELOW is not completed in ENTIRETY ******

		Points Assigned	Points Given
Thrombocytopenia	Platelet count fall > 50% **and** platelet nadir ≥ 20 x 10^9/L	**2**	
	Platelet count fall 30-50% **or** platelet nadir 10-19 x 10^9/L	**1**	
	Platelet count fall < 30% **or** platelet nadir < 10 x 10^9/L	**0**	
Timing * of platelet count fall * 1st day of heparin exposure = Day 0	Clear onset between days 5 – 14 **or** platelet fall ≤ 1 day (prior heparin exposure within 30 days)	**2**	
	Consistent with days 5 – 14 fall, but not clear (e.g. missing platelet counts) **or** onset after day 14 **or** fall ≤ 1 day (prior heparin exposure 30 – 100 days ago)	**1**	
	Platelet count fall ≤ 4 days without recent exposure	**0**	
Thrombosis or other sequelae (e.g. skin lesions)	New thrombosis (confirmed); skin necrosis at heparin injection sites; anaphylactoid reaction after IV heparin bolus; adrenal hemorrhage	**2**	
	Progressive or recurrent thrombosis; non-necrotizing (erythematous) skin lesions; suspected thrombosis (not confirmed)	**1**	
	None	**0**	
Other causes of thrombocytopenia	None apparent	**2**	
	Possible	**1**	
	Definite	**0**	
6 – 8 = High pre-test probability **4 – 5 = Intermediate pre-test probability** **0 – 3 = Low pre-test probability**		**TOTAL PRE-TEST PROBABILITY SCORE (0-8)**	

TEST	**SAMPLES REQUIRED**	**TEST CODE**
☐ **HIT Screen** **Note:** Positive HIT Screened specimens will be referred out for confirmatory SRA (Serotonin Release Assay)	**Serum for Heparin Induced Thrombocytopenia HIT** Adult: **1 x 10 mL tube (serum) – red top** **1 x 1.8 mL sodium citrate tubes (plasma) – light blue**	**HITA**

Physician Signature (required): _____ Print Name: _____ Contact Phone or Pager: _____

Shared health Soins communs Manitoba