

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.

FLOW CYTOMETRY LABORATORY REQUISITION

****REQUISITION MUST ACCOMPANY SPECIMEN TO FLOW CYTOMETRY LABORATORY ****

*Acceptance Policy 10-50-03 - Requirements for Test Requisitions 2.1 - All information marked with an * 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 MB Health Card)	
*Ordering Facility:	Inpatient Location:	* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: Female Male	
Critical Results Phone Number:	*Fax Number:	*PHIN:	
COLLECTION INFORMATION		ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	
*Collection Facility/Lab:		*Alternate ID: (include ID type with number ie. RCMP, SK, DND) MRN:	
*Collection Date:		Encounter Number:	
*Collection Time:		Demographics verified with: <input type="checkbox"/> Prov. Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR	
Referring Lab: <input type="checkbox"/> Check if samples shipped frozen <input type="checkbox"/>		Patient Phone No:	
Number of tubes sent: Serum vial(s) _____ Plasma vials(p) _____		Patient Address:	
ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION		ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	
Last & Full First Name:	Billing Code:	Last & Full First Name:	Billing Code:
Phone #:	Fax #:	Phone #:	Fax #:

<p>*Clinical Information/Diagnosis:</p> <p> <input type="checkbox"/> Lymphoma <input type="checkbox"/> CLL <input type="checkbox"/> Sezary Syndrome <input type="checkbox"/> Hairy Cell <input type="checkbox"/> Mastocytosis <input type="checkbox"/> Immune Deficiency <input type="checkbox"/> Acute Leukemia <input type="checkbox"/> Other: _____ </p> <p>Recent Transfusion: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____</p> <p>Current Radiation/Chemotherapy Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Monoclonal Antibody Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes Generic Name: _____</p>	LIS BARCODE LABEL
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<p>*Must be included for all testing excluding PB48 and FLFC</p> <p> <input type="checkbox"/> CBC with Automated Diff – Results Attached <input type="checkbox"/> CBC with Automated Diff – Sent for Testing at Shared Health Site </p>

Immune Monitoring		
<input type="checkbox"/> PB48	CD4 Count (CD3, CD4, CD8)	EDTA (< 48 hr)
<input type="checkbox"/> PBLS	Lymphocyte Subset Enumeration (T, B, NK)	EDTA (< 48 hr)

Immunodeficiency Investigation		
<input type="checkbox"/> RTE4	CD4+ Recent Thymic Emigrants (<i>Includes Naïve and Memory T Cells</i>)	EDTA (< 48 hr)
<input type="checkbox"/> PBBS	Advanced B Cell Phenotyping	EDTA (< 48 hr)
<input type="checkbox"/> PBTS	Advanced T Cell Phenotyping	EDTA (< 48 hr)
<input type="checkbox"/> TREG	Regulatory T Cells	EDTA (< 24 hr)
<input type="checkbox"/> LAD	Leukocyte Adhesion Deficiency (<i>Type I and II</i>)	EDTA (< 24 hr)
<input type="checkbox"/> OBRT	Neutrophil Function – Oxidative Burst (<i>Microtainer collections will be rejected</i>)	EDTA (< 24 hr)

Leukemia/Lymphoma Investigation		
<input type="checkbox"/> PBFC	Peripheral Blood Immunophenotyping (<i>Send 1 Unstained Smear</i>)	EDTA (< 72 hr)
<input type="checkbox"/> FLFC	Fluid Immunophenotyping (<i>CSF ONLY</i>)	RPML (< 72 hr)

Miscellaneous		
<input type="checkbox"/> PNH	Paroxysmal Nocturnal Hemoglobinuria	EDTA (< 48 hr)
<input type="checkbox"/> HSFC	Hereditary Spherocytosis (<i>Send 1 Unstained Smear</i>)	EDTA (< 48 hr)
<input type="checkbox"/> MIS8	Referral tests require prior approval. Complete the Immunology/Hematology Approval for Testing Form [F150-100-100]	

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Additional requisitions and sample requirements available at:
<https://apps.sbggh.mb.ca/labmanual/>

