

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.

Haemostasis Requisition *(Hematology Consult Required)*

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:	Billing Code:	*Last/First Name: (per Health Card)	
*Ordering Facility:		* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Critical Results Phone Number:	Fax No:	*PHIN: (Specify if other province/ DND)	
Physician Signature:	Phone No.:	MRN:	
Copy Report To: <i>(if info missing, report may not be sent)</i>		Encounter Number:	
Last & Full First Name:	Fax No:	Patient Phone No:	
Facility Name/ Address:	Phone No.:	Patient Address:	
Last & Full First Name:	Fax No:	Demographics verified:	
Facility Name/ Address:	Phone No.:	<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other	
Collection Information <i>(fields marked with ♦ required)</i>			
♦Collection: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line		♦ Collector:	♦ Collection Date:
# Serum tubes(s) _____ # Plasma tubes(p) _____		♦ Collection Facility/Lab:	♦ Collection Time:
Referring Lab: # of tubes sent _____		Samples shipped frozen <input type="checkbox"/>	
Medications		Patient History	
Provisional Diagnosis			
<input type="checkbox"/> Bleeding Profile with Platelet Studies CBW **Haemostasis Lab collection only • Closure times • Platelet Function-Platelet Aggregation, ATP Release, Electron Microscopy • von Willebrand studies – VW Antigen, VW Ristocetin Cofactor • Coagulation Assessment – PT, INR, PTT, Fibrinogen • Factor Assays		<input type="checkbox"/> Hypercoagulability Profile HYPE **Collection: 8 x 1.8 mL blue top tube • Coagulation Assessment – PT, INR, PTT, Fibrinogen, Factor Studies • Lupus Anticoagulant • Thrombin Time • Antithrombin • Plasminogen • Protein C Activity • Activated Protein C Resistance • Free Protein S Antigen	
<input type="checkbox"/> Platelet Function Profile PAGG **Haemostasis Lab collection only • Closure Times • Platelet Aggregation • ATP Release, Electron Microscopy		<input type="checkbox"/> Factor V Leiden and Prothrombin Variant MOL (Molecular Hematology Lab) **Collection: 1 lavender top tube	
<input type="checkbox"/> Bleeding Profile without Platelet Studies DHWU **Collection: 8 x 1.8 mL blue top tubes; 1 lavender top tube • Closure Times • von Willebrand studies – VW Antigen, VW Ristocetin Cofactor • Coagulation Assessment – PT, INR, PTT, Fibrinogen • Factor Assays		<input type="checkbox"/> Antiphospholipid Antibodies APHL (Immunology Lab) **Collection: 1 SST (yellow top tube)	
<input type="checkbox"/> Von Willebrand Profile / DDAVP Trial VONW **Collection 6 x 1.8 mL blue top tube; 1 lavender top tube • Closure Times • von Willebrand studies – VW Antigen, VW Ristocetin Cofactor • Factor VIII		<input type="checkbox"/> Lupus Anticoagulant Profile LUPS **Collection: 3x1.8 mL blue top tube • Lupus Anticoagulant	
<input type="checkbox"/> PFA-100 Closure Times PFA **Collection: 4 x 1.8 mL blue top tube; 1 lavender top tube		<input type="checkbox"/> Random Hypercoagulability Assay Profile RASS **Collection: 4 x 1.8 mL blue top tube Please specify: <input type="checkbox"/> Antithrombin <input type="checkbox"/> Activated Protein C Resistance <input type="checkbox"/> Plasminogen <input type="checkbox"/> Free Protein S Antigen <input type="checkbox"/> Protein C Activity	
<input type="checkbox"/> Factor Assay Profile FASS **Collection: 3 x 1.8 mL blue top tube Specify: <input type="checkbox"/> Fibrinogen <input type="checkbox"/> Factor II <input type="checkbox"/> Factor V <input type="checkbox"/> Factor VII <input type="checkbox"/> Factor VIII <input type="checkbox"/> Factor IX <input type="checkbox"/> Factor X <input type="checkbox"/> Factor XI <input type="checkbox"/> Factor XII <input type="checkbox"/> Factor XIII		<input type="checkbox"/> Coagulation Assessment PTTC *Collection: 4 x 1.8 mL blue top tube • PT, INR, PTT, Fibrinogen • Factor Assays • Other studies if needed – Lupus Anticoagulant, Thrombin Time	
<input type="checkbox"/> Factor Inhibitor Profile FINH **Collection: 6 x 1.8 mL blue top tube Specify: <input type="checkbox"/> Factor VIII <input type="checkbox"/> Factor IX <input type="checkbox"/> Other <input type="checkbox"/> Factor Inhibitor Screen <input type="checkbox"/> Bethesda Assay Please Specify Factor Therapy: _____		<input type="checkbox"/> DIC Profile DIC **Collection: 4 x 1.8 mL blue top tube • Coagulation assessment – PT, INR, PTT, Fibrinogen • Factor Assays • Soluble Fibrin Monomers, D-Dimer • Other studies if needed/requested – Lupus Anticoagulant, Thrombin Time	
<input type="checkbox"/> Chromogenic Factor Assay HEPX **Collection 1 x 1.8 mL blue top tube <input type="checkbox"/> Factor IX (FAIX) <input type="checkbox"/> Factor VIII (_____) Please specify: Please Specify: <input type="checkbox"/> Rebinyn <input type="checkbox"/> FVIII Therapy: Please indicate time of last dose: _____		<input type="checkbox"/> Heparin Anti-XA HEPX **Collection: 1 x 1.8 mL blue top tube Please specify: <input type="checkbox"/> Unfractionated Heparin <input type="checkbox"/> Dalteparin <input type="checkbox"/> Danaparoid <input type="checkbox"/> Enoxaparin <input type="checkbox"/> Fondaparinux Please indicate time of last dose: _____	