

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 (*Consult Required*)

Fields marked with \* are mandatory and must be clearly legible or can result in specimen rejection

<b>Ordering Provider Information</b>			<b>Patient Information</b> ( <i>print or use addressograph</i> )		
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)		
*Inpatient Location/Facility Name/Address:			* Date of Birth (dd/mm/yyyy)		
Ph #			*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
*Critical Results Ph #:		Fax #:	*PHIN: Specify Province or DND if different		
<b>Copy Report To</b> ( <i>if info missing, report may not be sent</i> ):					
Last & Full First Name:		Ph #:	Fax #:		
Facility Name/ Address:					
Last & Full First Name:		Ph #:	Fax #:		
Facility Name/ Address:					
Demographics verified via: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other					

## Collection Information (*fields marked with ♦ required*)

♦ 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"/>

**\*Consulting Hematologist name:**  
**OR Hematopathologist name:**  
*(initiate consult form F140-80-48A if hematopathologist)*  
<https://apps.sbg.h.mb.ca/labmanual/test/loadDocumentPdf?documentId=1921>

**Patient History:**

**Provisional Diagnosis:**

**Medications:**

<input type="checkbox"/> <b>Bleeding Profile with Platelet Studies</b> <b>CBW</b> <i>*Haemostasis Lab collection only</i> • Closure times • Platelet Function-Platelet Aggregation, ATP Release, Electron Microscopy • von Willebrand studies – VW Antigen, VW Activity • Coagulation Assessment – PT, INR, PTT, Fibrinogen • Factor Assays, Clot lysis/retraction
<input type="checkbox"/> <b>Platelet Function Profile</b> <i>*Haemostasis Lab collection only</i> <b>PAGG</b> • Closure Times • Platelet Aggregation • ATP Release, Electron Microscopy
<input type="checkbox"/> <b>Bleeding Profile without Platelet Studies</b> <b>DHWU</b> <i>*Collect: 8 x 1.8 mL blue top tubes; 1 x lavender top tube</i> • Closure Times • von Willebrand studies – VW Antigen, VW Activity • Coagulation Assessment – PT, INR, PTT, Fibrinogen • Factor Assays
<input type="checkbox"/> <b>Von Willebrand Profile / DDAVP Trial</b> <b>VONW</b> <i>*Collect: 6 x 1.8 mL blue top tube; 1 x lavender top tube</i> • Closure Times • von Willebrand studies – VW Antigen, VW Activity • Factor VIII
<input type="checkbox"/> <b>PFA Closure Times</b> <b>PFA</b> <i>*Collect: 3 x 1.8 mL blue top tube; 1 x lavender top tube</i>
<input type="checkbox"/> <b>Factor Assay Profile</b> <i>*Collect: 3 x 1.8 mL blue top tube</i> <b>FASS</b> 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"/> <b>Factor Inhibitor Profile</b> <i>*Collect: 6 x 1.8 mL blue top tube</i> <b>FINH</b> 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 Specify Factor Therapy: _____
<input type="checkbox"/> <b>Chromogenic Factor Assay</b> <i>*Collect: 1 x 1.8 mL blue top tube</i> <input type="checkbox"/> Factor IX (FAIX) <input type="checkbox"/> FIX Therapy: _____ <input type="checkbox"/> Factor VIII (CAF8) <input type="checkbox"/> FVIII Therapy: _____ Please indicate date and time of last dose: _____

<input type="checkbox"/> <b>Hypercoagulability Profile</b> <i>*Collect: 8 x 1.8 mL blue top tube</i> <b>HYPE</b> • 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"/> <b>Factor V Leiden and Prothrombin Variant</b> <i>*Collect: 1 x lavender</i> <b>MOL</b> (Genomics Lab) Consult <b>not</b> required
<input type="checkbox"/> <b>Antiphospholipid Antibodies</b> <i>*Collect: 1 x SST (yellow top tube)</i> <b>APHL</b> (Immunology Lab) Consult <b>not</b> required
<input type="checkbox"/> <b>Lupus Anticoagulant Profile</b> <i>*Collect: 3 x 1.8 mL blue top tube</i> <b>LUPS</b> Consult <b>not</b> required
<input type="checkbox"/> <b>Random Hypercoagulability Assay Profile</b> <b>RASS</b> <i>*Collect: 4 x 1.8 mL blue top tube</i> 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"/> <b>Coagulation Assessment</b> <i>*Collect: 4 x 1.8 mL blue top tube</i> <b>PTTC</b> • PT, INR, PTT, Fibrinogen • Factor Assays • Other studies if needed – Lupus Anticoagulant, Thrombin Time
<input type="checkbox"/> <b>DIC Profile</b> <i>*Collect: 4 x 1.8 mL blue top tube</i> <b>DIC</b> • 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"/> <b>Anti-Xa Profile</b> <i>*Collect: 1 x 1.8 mL blue top tube</i> <b>HEPX</b> Specify: <input type="checkbox"/> Unfractionated Heparin <input type="checkbox"/> Dalteparin <input type="checkbox"/> Danaparoid <input type="checkbox"/> Tinzaparin <input type="checkbox"/> Fondaparinux <input type="checkbox"/> Enoxaparin <input type="checkbox"/> Apixaban Please indicate date and time of last dose: _____