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

Ordering Provider Information		**Patient Information** *(print or use addressograph)*
*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: □ Female □ Male
*Critical Results Ph #:	Fax #:	*PHIN: Specify Province or DND if different
Copy Report To *(if info missing, report may not be sent)*:		MRN:
Last & Full First Name: Ph #:	Fax #:	Encounter #:
Facility Name/ Address:		
Last & Full First Name: Ph #:	Fax #:	
Facility Name/ Address:		Demographics verified via: ☐Health Card ☐Armband ☐eChart/CR ☐Other

Collection Information *(fields marked with ♦ required)*

♦Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line	♦ Collector: ♦ Collection Date:
	♦ Collection Facility/Lab: ♦ Collection Time:
# Serum tubes(s) _____ # Plasma tubes(p) _____	Referring Lab: # of tubes sent _____ Samples shipped frozen ❑
Consulting Hematologist name: ***OR Hematopathologist name:*** *(initiate consult form F140-80-48A if hematopathologist)* https://apps.sbgh.mb.ca/labmanual/test/loadDocumentPdf?documentId=1921	**Patient History:** **Provisional Diagnosis:** **Medications:**

❑ **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 Activity
- Coagulation Assessment – PT, INR, PTT, Fibrinogen
- Factor Assays, Clot lysis/retraction

❑ **Platelet Function Profile** ***Haemostasis Lab collection only*** **PAGG**
- Closure Times
- Platelet Aggregation
- ATP Release, Electron Microscopy

❑ **Bleeding Profile without Platelet Studies** **DHWU**
***Collect: 8 x 1.8 mL blue top tubes; 1 x lavender top tube**
- Closure Times
- von Willebrand studies – VW Antigen, VW Activity
- Coagulation Assessment – PT, INR, PTT, Fibrinogen
- Factor Assays

❑ **Von Willebrand Profile / DDAVP Trial** **VONW**
***Collect: 6 x 1.8 mL blue top tube; 1 x lavender top tube**
- Closure Times
- von Willebrand studies – VW Antigen, VW Activity
- Factor VIII

❑ **PFA Closure Times** **PFA**
***Collect: 3 x 1.8 mL blue top tube; 1 x lavender top tube**

❑ **Factor Assay Profile** ***Collect: 3 x 1.8 mL blue top tube** **FASS**
Specify: ❑Fibrinogen ❑Factor II ❑Factor V
❑Factor VII ❑Factor VIII ❑Factor IX ❑Factor X
❑Factor XI ❑Factor XII ❑Factor XIII

❑ **Factor Inhibitor Profile** ***Collect: 6 x 1.8 mL blue top tube** **FINH**
Specify: ❑Factor VIII ❑Factor IX ❑Other
❑Factor Inhibitor Screen ❑Bethesda Assay
Specify Factor Therapy: _____

❑ **Chromogenic Factor Assay** ***Collect: 1 x 1.8 mL blue top tube**
❑ Factor IX (**FAIX**) ❑ FIX Therapy: _____
❑ Factor VIII (**CAF8**) ❑ FVIII Therapy: _____
Please indicate date and time of last dose: _____

❑ **Hypercoagulability Profile** ***Collect: 8 x 1.8 mL blue top tube** **HYPE**
- 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

❑ **Factor V Leiden and Prothrombin Variant** ***Collect: 1 x lavender (Genomics Lab)** Consult **not** required **MOL**

❑ **Antiphospholipid Antibodies** ***Collect: 1 x SST (yellow top tube) (Immunology Lab)** Consult **not** required **APHL**

❑ **Lupus Anticoagulant Profile** ***Collect: 3 x 1.8 mL blue top tube** **LUPS**
Consult **not** required

❑ **Random Hypercoagulability Assay Profile** **RASS**
***Collect: 4 x 1.8 mL blue top tube**
Please specify:
❑Antithrombin ❑Activated Protein C Resistance
❑Plasminogen ❑Free Protein S Antigen ❑Protein C Activity

❑ **Coagulation Assessment** ***Collect: 4 x 1.8 mL blue top tube** **PTTC**
- PT, INR, PTT, Fibrinogen
- Factor Assays
- Other studies if needed – Lupus Anticoagulant, Thrombin Time

❑ **DIC Profile** ***Collect: 4 x 1.8 mL blue top tube** **DIC**
- Coagulation assessment – PT, INR, PTT, Fibrinogen
- Factor Assays
- Soluble Fibrin Monomers, D-Dimer
- Other studies if needed/requested – Lupus Anticoagulant, Thrombin Time

❑ **Anti-Xa Profile** ***Collect: 1 x 1.8 mL blue top tube** **HEPX**
Specify:
❑Unfractionated Heparin ❑Dalteparin ❑Danaparoid ❑Tinzaparin
❑Fondaparinux ❑Enoxaparin ❑Apixaban
Please indicate date and time of last dose: _____