

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.

# MOLECULAR HEMATOPATHOLOGY TEST REQUISITION

Acceptance Policy 10-50-03 - Requirements for Test Requisitions 2.1 - Fields marked with \* are mandatory and must be clearly legible. Failure to comply may result in specimen rejection.  
 \*\*\* PLEASE COMPLETE THE INFORMATION BELOW. PRINT CLEARLY. CHECK APPROPRIATE PROFILE \*\*\*

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION		
*Last & Full First Name:	Billing Code:	*Last/First Name: (per MB. Health Card)		
*Ordering Facility:	Inpatient Location:	* Date of Birth (dd/mm/yyyy)		
Address:		*Sex: Female Male		
Critical Results Phone Number:	Fax No:	*PHIN:		
Physician Signature:	Phone No:	Specify if other province or DND		
COPY REPORT TO: (if info missing, report may not be sent)				
Last & Full First Name:	Fax No:	MRN:		
Facility Name/Address:	Phone No:	Encounter Number:		
Last & Full First Name:	Fax No:	Patient Phone No:		
Facility Name/Address:	Phone No:	Patient Address:		
		Demographics verified with: <input type="checkbox"/> Prov. Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR		
COLLECTION INFORMATION (fields marked with ♦ required by person collecting sample)				
♦ Collector:	♦ Collection Date:	♦ Collected Via: <input type="checkbox"/> Venipuncture		
♦ Collection Facility/Lab:	♦ Collection Time:	<input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line <input type="checkbox"/> Above shut off IV		
# Serum vial(s) _____ # Plasma vials (p) _____	Referring Lab: Number of tubes sent _____	Samples shipped frozen <input type="checkbox"/>		
<b>Sample Type</b> <input type="checkbox"/> Peripheral Blood <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Formalin-fixed Paraffin-embedded Case #: _____ <input type="checkbox"/> Fresh/Frozen Tissue <input type="checkbox"/> Other _____		<b>Clinical History</b>		
IN-HOUSE TEST NAME & PURPOSE		CODE	Previous Testing	
<input type="checkbox"/> Factor V Leiden and Prothrombin G20210A Mutation Hypercoagulability/Thrombophilia (diagnostic)	MOL	Other Testing Requirement		
<input type="checkbox"/> B Cell Clonality, Immunoglobulin Gene Rearrangement B cell lymphoma (diagnostic)	HMD			
<input type="checkbox"/> T Cell Clonality, T Cell Receptor Gene Rearrangement T cell lymphoma (diagnostic)	HMD	REFERRED OUT TEST NAME & PURPOSE		
<input type="checkbox"/> BCR/ABL1 Diagnostic Screen (non-quantitative) t(9;22) Philadelphia Chromosome CML, ALL (diagnostic)	HMD	<input type="checkbox"/> ABL1 Tyrosine Kinase Inhibitor Resistance Screen CML, ALL (prognostic)	Mayo	HMD
<input type="checkbox"/> BCR/ABL1 Quantitative Monitoring, RQ BCR/ABL1 CML, ALL (follow-up)	HMD	<input type="checkbox"/> CEBPA Mutation Testing AML (diagnostic)	Mayo	HMD
<input type="checkbox"/> PML/RARA Diagnostic Screen (non-quantitative), t(15;17) APL (diagnostic and follow-up)	HMD	<input type="checkbox"/> CALR Myeloproliferative Neoplasm (MPN)	Mayo	HMD
<input type="checkbox"/> RUNX1/RUNX1T1 (AML1/ETO) Rearrangement, t(8;21) AML (diagnostic)	HMD	<input type="checkbox"/> Myeloid NGS Panel AML (diagnostic)	LHSC	HMD
<input type="checkbox"/> CFBF/MYH11 Rearrangement, inv(16), t(16;16) AML (diagnostic)	HMD	Prognostic testing requires a funding approval letter from the applicable Regional Health Authority. Submit samples and completed requisition to: Shared Health Molecular Hematopathology Laboratory Health Sciences Centre MS559-820 Sherbrook Street Winnipeg, MB R3A 1R9		
<input type="checkbox"/> ETV6/RUNX1 (TEL/AML1) Rearrangement, t(12;21) ALL (diagnostic)	HMD			
<input type="checkbox"/> JAK2 V617F Mutation (quantitative) Myeloproliferative neoplasm (diagnostic)	JAK2			
<input type="checkbox"/> FLT3/NPM1 AML (diagnostic)	HMD			
<input type="checkbox"/> C-KIT Sequencing Analysis Mastocytosis/AML (diagnostic)	MD			