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	
***Last & Full First Name:**	**Billing Code:**
***Ordering Facility:**	**Inpatient Location**:
Address:	
Critical Results Phone Number:	**Fax No:**
Physician Signature:	**Phone No:**
COPY REPORT TO: (if info missing, report may not be sent)	
Last & Full First Name:	**Fax No:**
Facility Name/Address:	**Phone No:**
Last & Full First Name:	**Fax No:**
Facility Name/Address:	**Phone No:**

PATIENT INFORMATION

*Last/First Name: (per MB. Health Card)

* Date of Birth (dd/mm/yyyy)

*Sex: Female Male

*PHIN:

Specify if other province or DND

MRN:

Encounter Number:

Patient Phone No:

Patient Address:

Demographics verified with: ❑ Prov. Health Card ❑ Armband ❑eChart/CR

COLLECTION INFORMATION (fields marked with ♦ required by person collecting sample)

♦ Collector:	♦ Collection Date:	♦ Collected Via: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Above shut off IV
♦ Collection Facility/Lab:	♦ Collection Time:	
# Serum vial(s) _____ # Plasma vials (p) _____	Referring Lab: Number of tubes sent ____	Samples shipped frozen ❑

Sample Type

☐ **Peripheral Blood**
☐ **Bone Marrow**
☐ **Formalin-fixed Paraffin-embedded**
☐ **Fresh/Frozen Tissue**
☐ **Other** _____

Case #: _____

Clinical History

	IN-HOUSE TEST NAME & PURPOSE	CODE
☐	**Factor V Leiden and Prothrombin G20210A Mutation** Hypercoagulability/Thrombophilia (diagnostic)	MOL
☐	**B Cell Clonality, Immunoglobulin Gene Rearrangement** B cell lymphoma (diagnostic)	HMD
☐	**T Cell Clonality, T Cell Receptor Gene Rearrangement** T cell lymphoma (diagnostic)	HMD
☐	**BCR/ABL1 Diagnostic Screen (non-quantitative) t(9;22) Philadelphia Chromosome** CML, ALL (diagnostic)	HMD
☐	**BCR/ABL1 Quantitative Monitoring, RQ BCR/ABL1** CML, ALL (follow-up)	HMD
☐	**PML/RARA Diagnostic Screen (non-quantitative), t(15;17)** APL (diagnostic and follow-up)	HMD
☐	**RUNX1/RUNX1T1 (AML1/ETO) Rearrangement, t(8;21)** AML (diagnostic)	HMD
☐	**CBFB/MYH11 Rearrangement, inv(16), t(16;16)** AML (diagnostic)	HMD
☐	**ETV6/RUNX1 (TEL/AML1) Rearrangement, t(12;21)** ALL (diagnostic)	HMD
☐	**JAK2 V617F Mutation (quantitative)** Myeloproliferative neoplasm (diagnostic)	JAK2
☐	**FLT3/NPM1** AML (diagnostic)	HMD
☐	**C-KIT Sequencing Analysis** Mastocytosis/AML (diagnostic)	MD

Previous Testing

Other Testing Requirement

	REFERRED OUT TEST NAME & PURPOSE	SITE	CODE
☐	**ABL1 Tyrosine Kinase Inhibitor Resistance Screen** CML, ALL (prognostic)	Mayo	HMD
☐	**CEBPA Mutation Testing** AML (diagnostic)	Mayo	HMD
☐	**CALR** Myeloproliferative Neoplasm (MPN)	Mayo	HMD
☐	**Myeloid NGS Panel** AML (diagnostic)	LHSC	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