PERITONEAL DIALYSIS - Kt/V REQUISITION

*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	
*Last & Full First Name:	Billing Code:
*Ordering Facility:	Inpatient Location:
Address:	
Critical Results Phone Number:	Fax No:
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 Health Card)

* Date of Birth (dd/mm/yyyy)

*Sex: Female Male

*PHIN:

Specify if other province/ DND)

MRN:

Encounter Number:

Patient Phone No:

Patient Address:

Demographics verified via:
❑ Health Card ❑ Armband ❑eChart/CR ❑ Other

PERITONEAL DIALYSIS INFORMATION

□ Has blood work been collected for Glucose, Albumin, Creatinine and Urea?

□ No urine collected

SPECIMENS: 24 hr URINE and DIALYSATE

(Each bag must be double knotted and clamped to prevent leakage)

Collection Date: (dd/mm/yyyy)	Height (cm)
	Weight (kg)

Below information is for lab use

DIALYSATE MEASUREMENT

Bag #	Bag Type	Full Weight (g)	Dry Weight (g)	Extra Clip?	True Volume (mL)	Aliquot (x 0.001)
					mL	L

Urine Measurement

Full Weight	Container Weight	True Volume (mL)	Volume in Litres (to be reported in Delphic)

Place lab bar code label here