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.

IMMUNOLOGY AUTOIMMUNE LABORATORY REQUISITION

	Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields man					ced with * are mandatory and must be c	learly	legible or can	result in specimen rejection.	
ORDERING PROVIDER INFORMATION				V		PATIENT INFORMATION				
*Last & Full Billing (First Name:		ng Code:	g Code:		*Last/First Name: (per MB Health Card)					
		atient Location:			* Date of Birth (dd/mm/yyyy)					
Address						*Sex: Female Male				
Critical Results Phone Number: Fax No:					*PHIN:					
Phone No.:						*Specify Province or DND if different				
COPY REPORT TO: (If info missing, report may not be sent)					•)	d ' '				
	KEPORT TO: (If info miss	ıng, repo				MRN:				
First Name:			Fax No:	: 		Encounter Number:				
Facility Name/Address: Ph			Phone	No:		Patient Phone Number:				
Last & Full Fa		Fax No:	:		Patient Address:					
		Phone	Phone No:		Demographics verified with: ☐ Prov. Health Card ☐ Armband ☐ eChart/CR					
					marked v	with [†] required by person collecting sample)				
♦ Collector: ♦ Collectio ♦ Collection Facility/Lab: ♦ Collectio					◆Collected via: ☐ Venipuncture ☐ Capillary ☐ Indwelling Line					
# Serum vial(s) # Plasma					Referring Lab: # of tubes sent Samples shipped frozen 🗖					
Clinical Information/Diagnosis:										
									LAB USE ONLY	
								DI A	ACE BARCODE HERE	
								F L/	ACL DANCODE HERE	
Connective Tissue Disease (IFA/LIA, EIA)			Rh	Rheumatoid Arthritis (EIA)			M	yastheni	a Gravis (IFA, EIA)	
☐ HEP2 Antinuclear Ab HEP2 Substrate								ACHR	Acetylcholine Receptor	
□ DNA Double Stranded DNA								STR	Striated Muscle	
Inflammatory Bowel Disease (IFA/EIA)				Antiphospholipid Syndrome (EIA)			Ru	illous De	wasteses (IFA)	
☐ IBD Inflammatory Bowel Disease Profile		'EIA)	An	ntipnospn	☐ APHL Antiphospholipid Profile				rmatoses (IFA)	
☐ IBD Inflammatory Bowel Disease Profile Anti-Saccharomyces Cerevisiae(IgG/IgA)								ABD	rmatoses (IFA) Autoimmune Bullous Dermatoses	
	Inflammatory Bowel Disea	se Profile			Antiphos					
	Inflammatory Bowel Disea Anti-Saccharomyces Cere Cytoplasmic Neutrophilic	nse Profile visiae(IgG/	lgA)	APHL	Antiphos Cardiol Beta-2-	spholipid Profile ipin IgG/IgM glycoprotein IgG/IgM		ABD	Autoimmune Bullous Dermatoses [PGUS, DSG1 & 3, PGOID, BP180 & 230, Salt Split Skin]	
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Immunology Laboratory, St. Boniface Hospital

L1011, 409 Tache Avenue Winnipeg, MB R2H 2A6

https://apps.sbgh.mb.ca/labmanual/

Additional requisitions and sample requirements available at:

R250-10-85 V02 Phone: 204-237-2026 Fax: 204-233-0826 Effective date: 8-JUL-2022