

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.

THIS SPACE FOR LAB USE ONLY:
PLACE LIS LABEL HERE:

HEMATOLOGY SERVICES

BONE MARROW REQUISITION

THIS SPACE FOR LAB USE ONLY:
PLACE HMD LABEL HERE:

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		PATIENT INFORMATION
*Last & Full First Name:		*Last/First Name: (per MB Health Card)
Billing Code:	Inpatient Location:	* Date of Birth (dd/mm/yyyy)
*Facility Name/Address		*Sex: Female Male
Phone No:	Fax No:	*PHIN:
Critical Results Phone Number:		*Specify Province or DND if different
COPY REPORT TO: (If info missing, report may not be sent)		MRN:
Last & Full First Name:	Fax No:	Encounter Number:
Facility Name/Address:	Phone No:	Patient Phone Number:
Last & Full First Name:	Fax No:	Patient Address:
Facility Name/Address:	Phone No:	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:	♦Collection Facility/Lab:
		♦Collection Time:

BM #: _____	<input type="checkbox"/> ASPIRATE(S) [BM]	<input type="checkbox"/> BIOPSY(S) [BMP, BMBX]
SPECIMEN SITE:		
<input type="checkbox"/> ILIAC CREST	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> STERNAL	<input type="checkbox"/> BILATERAL	<input type="checkbox"/> OTHER
Aspirated by (physician): _____		
CLINICAL INFORMATION: <input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> STAGING <input type="checkbox"/> FOLLOW-UP		
<input type="checkbox"/> CYTOPENIA(S) _____		
<input type="checkbox"/> LEUKEMIA -TYPE: _____		
<input type="checkbox"/> LYMPHOMA – TYPE: _____		
<input type="checkbox"/> MONOCLONAL PEAK - TYPE: _____		
<input type="checkbox"/> PLASMA CELL DYSCRASIA – TYPE: _____		
<input type="checkbox"/> MYELOPROLIFERATIVE DISORDER – TYPE: _____		
<input type="checkbox"/> MYELODYSPLASIA _____		
<input type="checkbox"/> OTHER: _____		
<input type="checkbox"/> CLINICAL COMMENTS: _____		

THERAPY: <input type="checkbox"/> NONE		
<input type="checkbox"/> GCSF (CYTOKINES) _____	<input type="checkbox"/> ANTIBODY THERAPY _____	
<input type="checkbox"/> BMT – TYPE: _____	<input type="checkbox"/> CHEMOTHERAPY: _____	
<input type="checkbox"/> TRIAL / STUDY: _____	<input type="checkbox"/> OTHER: _____	
ANCILLARY STUDIES (tubes collected) Subject to triage by a Hematopathologist. <input type="checkbox"/> NONE		
<input type="checkbox"/> MOLECULAR STUDIES: _____	<input type="checkbox"/> CYTOGENETICS: _____	
<input type="checkbox"/> FLOW CYTOMETRY: _____	<input type="checkbox"/> OTHER: _____	
SPECIAL CLINICAL REQUESTS: _____		

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HEMATOLOGY SERVICES

BONE MARROW REQUISITION

THIS SPACE FOR LAB USE ONLY:
PLACE AP LABEL HERE:

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*Last & Full First Name:		*Last/First Name: (per MB Health Card)
Billing Code:	Inpatient Location:	* Date of Birth (dd/mm/yyyy)
*Facility Name/Address		*Sex: Female Male
Phone No:	Fax No:	*PHIN:
Critical Results Phone Number:		*Specify Province or DND if different
COPY REPORT TO: (If info missing, report may not be sent)		MRN:
Last & Full First Name:	Fax No:	Encounter Number:
Facility Name/Address:	Phone No:	Patient Phone Number:
Last & Full First Name:	Fax No:	Patient Address:
Facility Name/Address:	Phone No:	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:	♦Collection Facility/Lab:
		♦Collection Time:

BM #:	<input type="checkbox"/> ASPIRATE(S) [BM]	<input type="checkbox"/> BIOPSY(S) [BMP, BMBX]
SPECIMEN SITE:		
<input type="checkbox"/> ILIAC CREST	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> STERNAL	<input type="checkbox"/> BILATERAL	<input type="checkbox"/> OTHER
Aspirated by (physician):		
CLINICAL INFORMATION: <input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> STAGING <input type="checkbox"/> FOLLOW-UP		
<input type="checkbox"/> CYTOPENIA(S)		
<input type="checkbox"/> LEUKEMIA -TYPE:		
<input type="checkbox"/> LYMPHOMA – TYPE:		
<input type="checkbox"/> MONOCLONAL PEAK - TYPE:		
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<input type="checkbox"/> MYELODYSPLASIA		
<input type="checkbox"/> OTHER:		
<input type="checkbox"/> CLINICAL COMMENTS:		
THERAPY: <input type="checkbox"/> NONE		
<input type="checkbox"/> GCSF (CYTOKINES)	<input type="checkbox"/> ANTIBODY THERAPY	
<input type="checkbox"/> BMT – TYPE:	<input type="checkbox"/> CHEMOTHERAPY:	
<input type="checkbox"/> TRIAL / STUDY:	<input type="checkbox"/> OTHER:	
ANCILLARY STUDIES (tubes collected) Subject to triage by a Hematopathologist. <input type="checkbox"/> NONE		
<input type="checkbox"/> MOLECULAR STUDIES:	<input type="checkbox"/> CYTOGENETICS:	
<input type="checkbox"/> FLOW CYTOMETRY:	<input type="checkbox"/> OTHER:	
SPECIAL CLINICAL REQUESTS:		