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: ❑ Prov. Health Card ❑ Armband ❑ eChart/CR

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

♦**Collector:**	♦**Collection Date:**	♦**Collection Facility/Lab:**	♦**Collection Time:**

BM #: _____ ☐ **ASPIRATE(S) [BM]** ☐ **BIOPSY(S) [BMP, BMBX]**

SPECIMEN SITE:

☐ ILIAC CREST ☐ L ☐ R ☐ BILATERAL
☐ STERNAL ☐ OTHER Aspirated by (physician): _____

CLINICAL INFORMATION: ☐ DIAGNOSTIC ☐ STAGING ☐ FOLLOW-UP

- ☐ CYTOPENIA(S) _____
- ☐ LEUKEMIA -TYPE: _____
- ☐ LYMPHOMA – TYPE: _____
- ☐ MONOCLONAL PEAK - TYPE: _____
- ☐ PLASMA CELL DYSCRASIA – TYPE: _____
- ☐ MYELOPROLIFERATIVE DISORDER – TYPE: _____
- ☐ MYELODYSPLASIA _____
- ☐ OTHER: _____
- ☐ CLINICAL COMMENTS: _____

_____

_____

THERAPY: ☐ **NONE**

- ☐ GCSF (CYTOKINES) _____
- ☐ BMT – TYPE: _____
- ☐ TRIAL / STUDY: _____
- ☐ ANTIBODY THERAPY _____
- ☐ CHEMOTHERAPY: _____
- ☐ OTHER: _____

ANCILLARY STUDIES (tubes collected) *Subject to triage by a Hematopathologist.* ☐ **NONE**

- ☐ MOLECULAR STUDIES: _____
- ☐ FLOW CYTOMETRY: _____
- ☐ CYTOGENETICS: _____
- ☐ OTHER: _____

SPECIAL CLINICAL REQUESTS: _____

_____

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

HEMATOLOGY SERVICES

BONE MARROW REQUISITION

THIS SPACE FOR LAB USE ONLY:
PLACE AP 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: ❑ Prov. Health Card ❑ Armband ❑ eChart/CR

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

♦**Collector:**	♦**Collection Date:**	♦**Collection Facility/Lab:**	♦**Collection Time:**

BM #: _____ ☐ **ASPIRATE(S) [BM]** ☐ **BIOPSY(S) [BMP, BMBX]**

SPECIMEN SITE:

☐ ILIAC CREST ☐ L ☐ R ☐ BILATERAL
☐ STERNAL ☐ OTHER Aspirated by (physician): _____

CLINICAL INFORMATION: ☐ DIAGNOSTIC ☐ STAGING ☐ FOLLOW-UP

- ☐ CYTOPENIA(S) _____
- ☐ LEUKEMIA -TYPE: _____
- ☐ LYMPHOMA – TYPE: _____
- ☐ MONOCLONAL PEAK - TYPE: _____
- ☐ PLASMA CELL DYSCRASIA – TYPE: _____
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_____

_____

THERAPY: ☐ **NONE**

- ☐ GCSF (CYTOKINES) _____
- ☐ BMT – TYPE: _____
- ☐ TRIAL / STUDY: _____
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- ☐ CHEMOTHERAPY: _____
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ANCILLARY STUDIES (tubes collected) *Subject to triage by a Hematopathologist.* ☐ **NONE**

- ☐ MOLECULAR STUDIES: _____
- ☐ FLOW CYTOMETRY: _____
- ☐ CYTOGENETICS: _____
- ☐ OTHER: _____

SPECIAL CLINICAL REQUESTS: _____

_____