

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.

# SPECIALIZED ENDOCRINOLOGY REQUISITION

Use of this requisition is restricted to approved physicians

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.  
Failure to comply may result in specimen rejection.

Complete collection information can be found in the Lab Information Manual (LIM) at <https://apps.sbg.mb.ca/labmanual/test/findTestPrepare>

<b>Ordering Provider Information</b>			<b>Patient Information</b> (print or use addressograph)		
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)		
*Facility Name / Address:			* Date of Birth (dd/mm/yyyy)		
			*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Critical Results Ph #:		Fax #:	*PHIN/MHSC: Specify if other province/ DND		
Provider Signature:		Ph #:	MRN:		
<b>Copy Report To</b> (if info missing, report may not be sent):			Encounter#:		
Last & Full First Name:	Ph #:	Fax #:	Patient Phone #:		
Facility Name/ Address:			Patient Address:		
Last & Full First Name:		Ph #:	Demographics verified via:		
Facility Name/ Address:		Fax #:	<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other		
<b>COLLECTION INFORMATION</b> (fields marked with ♦ required by person collecting sample)					
♦ Collector:		♦ Collection Date:		♦ Collected Via: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line	
♦ Collection Facility/Lab:		♦ Collection Time:		Has patient stopped taking any supplements for 48 hrs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
# Serum vial(s) _____		# Plasma vials (p) _____		Referring Lab: # of tubes sent _____	
				Samples shipped frozen <input type="checkbox"/>	
<b>No vitamins or dietary supplements for at least 48 hours prior to specimen collection</b>					
<input type="checkbox"/> Thyroid Reflex Testing (includes reflex testing if TSH abnormal)	TSH	<input type="checkbox"/> Hemoglobin A1c	GYHB	<input type="checkbox"/> Cortisol	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Other COR
<input type="checkbox"/> Free T4	FT4	<input type="checkbox"/> Glucose	G	<input type="checkbox"/> ACTH (see LIM <sup>1</sup> for collection & transport)	ACTH
<input type="checkbox"/> Free T3	FT3	<input type="checkbox"/> Lipid Profile (Cholesterol, Trig, HDLC, LDL, Non-HDL)	LIPP	<input type="checkbox"/> Aldosterone	ALDO
<input type="checkbox"/> Thyroperoxidase Antibodies	TPO	<input type="checkbox"/> Creatinine (eGFR automatically calculated in out-patients > 18 years)	CR	<input type="checkbox"/> Renin (Renin & aldosterone must be on same requisition for ratio)	REN
<input type="checkbox"/> TSH Receptor Antibody	TRAB	<input type="checkbox"/> Sodium	NA	<input type="checkbox"/> DHEA-S	DHAS
<input type="checkbox"/> Thyroglobulin (Anti-thyroglobulin automatically performed)	THGL	<input type="checkbox"/> Potassium	K	<input type="checkbox"/> Follicle Stimulating Hormone	FSH
<input type="checkbox"/> Calcium	CA	<input type="checkbox"/> Chloride	CL	<input type="checkbox"/> Luteinizing Hormone	LH
<input type="checkbox"/> Albumin	AL	<input type="checkbox"/> Osmolality	OS	<input type="checkbox"/> Estradiol	E2
<input type="checkbox"/> Phosphate	P	<input type="checkbox"/> ALT	ALT/ALTR	<input type="checkbox"/> Progesterone	PGN
<input type="checkbox"/> Magnesium	MG	<input type="checkbox"/> Creatine Kinase	CK	<input type="checkbox"/> Testosterone (AM recommended. Lab will add albumin for males over 17)	TST
<input type="checkbox"/> Parathyroid hormone	PTH	<input type="checkbox"/> Glutamic Acid Decarboxylase Ab	GADA	<input type="checkbox"/> Free Androgen Index	FAI
<input type="checkbox"/> Ionized calcium	ICA	<input type="checkbox"/> Islet Antigen 2 (IA-2) Antibody	IA2	<input type="checkbox"/> Prolactin	PL
<input type="checkbox"/> Vitamin D-1,25	D125	<input type="checkbox"/> C-Peptide	CP	<input type="checkbox"/> Growth Hormone (for concurrent hypoglycemia)	GH
<input type="checkbox"/> CBC	CBC	<input type="checkbox"/> Insulin	INS	<input type="checkbox"/> Insulin-Like Growth Factor 1	IGF1
		<input type="checkbox"/> Insulin antibodies	INAA	<input type="checkbox"/> 17-Hydroxyprogesterone	PR17
				<input type="checkbox"/> HCG (Quantitative)	HCGQ
<b>Other Tests</b>					