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.

Hospital Biochemistry / Hematology Requisition

Outside Winnipeg and Brandon Hospitals

THIS SPACE FOR LAB USE ONLY
PLACE LIS LABEL HERE

Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection

Ordering Provider Information		**Patient Information** *(print or use addressograph)*
*Last & Full First Name:	Billing Code:	*Last/First Name: (per Health Card)
*Inpatient Location/Facility Name/Address:		* Date of Birth (dd/mm/yyyy)
Ph #		*Sex: □ Female □ Male
*Critical Results Ph #:	Fax #:	*PHIN: Specify Province or DND if different
Copy Report To *(if info missing, report may not be sent)*:		MRN:
Last & Full First Name: Ph #: Fax #:		Encounter #:
Facility Name/ Address:		
Last & Full First Name: Ph #: Fax #:		
Facility Name/ Address:		Demographics verified via: ☐Health Card ☐Armband ☐eChart/CR ☐Other

§Fast *(nothing to eat, drink or chew) for:* ❑ 8-12h ❑ Alternate time _____h ❑ Fasting not required *(if not checked, assume fasting not required)*

Collection Information (fields marked with ♦ required by person collecting sample)

♦Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Arterial Puncture	♦ Collector:	♦ Collection Date:
	♦ Collection Facility/Lab:	♦ Collection Time:
# Serum tubes _____ # Plasma tubes _____	Referring Lab: # of tubes sent _____	Samples shipped frozen ❑

Fasting information ❑ **No** ❑ **Yes** **# of hours**_____

	Biochemistry				**Therapeutic Drug Monitoring**	
❑	Sodium	NA/NAR	❑	C-Reactive Protein RCRP/CRP	❑ Gentamicin Trough level	GENT
❑	Potassium	K/KR	❑	Creatine Kinase CK	❑ Gentamicin Peak level	GEPK
❑	Chloride	CL/CLR	❑	Ferritin FER	❑ Gentamicin Random level	RGEN
❑	Total CO2/Bicarbonate	CO2	❑	HCG Quantitative HCGQ	❑ Lithium	LI
❑	Glucose§	G	❑	HCG Qualitative (if HCGQ unavailable) HCGS	❑ Methotrexate	MTX
❑	Creatinine	CR	❑	%TSAT *(incl. iron, TIBC)* § IRON/IROR	❑ Mycophenolic acid	MYPA
❑	eGFR	EGFR	❑	Lactate LAC	❑ Phenobarbital	PHEN
❑	Urea	U	❑	Lactate Dehydrogenase LD/LDH	❑ Phenytoin	PYN
❑	Calcium	CA	❑	Lipase LIP/LIPA	❑ Sirolimus	SIRO
❑	Total Protein	TP	❑	Lipid Panel§ LIPP	❑ Tacrolimus	FK5
❑	Albumin	AL	❑	Triglycerides Only § TG	❑ Tobramycin Trough level	TOBR
❑	Bilirubin, Total	TB	❑	Magnesium MG	❑ Tobramycin Peak level	TOPK
❑	Alanine Transaminase	ALTR	❑	Osmolality OS	❑ Tobramycin Random level	RTOB
❑	Y-Glutamyl Transferase	GGT	❑	Osmolality *(Calculated)* OSCA	❑ Valproic acid	VALP
❑	Alkaline Phosphatase	ALK/ALKP	❑	Phosphate P	❑ Vancomycin Trough level	VANC
	Blood Gases (pH, HCO_3, PCO_2, PO_2)		❑	Troponin *(method based on site)* HTNT/HTNI	❑ Vancomycin Peak level	VAPK
❑	Arterial Blood Gas	AGAS	❑	NT-proBNP NBNP	❑ Vancomycin Random level	RVAN
❑	Venous Blood Gas	VGAS	❑	Uric Acid UA	**TDM Dose info *(must be completed)***	
❑	Capillary Blood Gas	CGAS		**Therapeutic Drug Monitoring**	Last dose date/time:	
❑	Mixed Blood Gas *(from a line)*	MGAS	❑	Carbamazepine CARB	Next dose date/time:	
❑	Umbilical Arterial Blood Gas	UAGS	❑	Cyclosporine CY	**Toxic Exposure**	
❑	Umbilical Venous Blood Gas	UVGS	❑	Digoxin DIG	❑ Ethanol	ETO
	Hematology				❑ Acetaminophen	ACTM
❑	CBC *(incl. differential)*	CBC	❑	Basic DIC Screen *(PT/PTT/FIB/DDIMER/CBC)* BASD	❑ Salicylate	SAL
❑	Reticulocyte count	RETA	❑	Sickle Cell Screen HSS	❑ Ethylene Glycol ***(Sent to SBH)***	EGOL
❑	Reticulocyte hemoglobin	RETA	❑	Erythrocyte Sedimentation Rate ESR *(Cannot be ordered with CRP unless approved)*	❑ Volatile Screen ***(Sent to SBH)*** *(incl. Ethanol, Methanol, Isopropanol and Acetone)*	ALC
❑	HemoCue WBC	IWBC				
❑	HemoCue HGB	IHGB	❑	Lupus Inhibitor LUPS	**Urinalysis**	
❑	PT/INR	PT/ IINR	❑	Fibrinogen CFIB	❑ Urinalysis (dipstick only)	UR
Is patient on anticoagulant: ❑No ❑ Yes *(specify):*			❑	Infectious Mononucleosis MS	❑ Urine Pregnancy Test	PREG
❑	D Dimer	DDIM	❑	Malaria*** MAL *(does not detect other blood micro-organisms; if suspected, check below)*	**Other Biochemistry/Hematology Tests**	
❑	aPTT *(**__must__ indicate condition)*	APTT	❑	Other blood parasites*** BPNM		
❑ Unfractionated Heparin ❑ Liver Transplant ❑Cord blood ❑Other, *please specify*:			*** For Malaria and other non-malarial blood parasites, complete the following: **Fever?** ❑Yes ❑ No			
Recommend hematology consult for unexplained bleeding			***Recent travel history required:*** *When: Where:*			