

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:	*Critical Results Ph #:		* Date of Birth (dd/mm/yyyy)		
*Facility Name/ Address			*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
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:			Patient Ph #:		
Last & Full First Name:	Ph #:	Fax #:	Patient Address:		
Facility Name/ Address:			Demographics verified via: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other		
Patient Preparation Instruction (to be completed by ordering physician)					
[§] Fast (nothing to eat, drink or chew) for: <input type="checkbox"/> 8-12h <input type="checkbox"/> Alternate time ____ h <input type="checkbox"/> Fasting not required (if not checked, assume fasting not required)					
Collection Information (fields marked with ♦ required by person collecting sample)					
♦Collection: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line <input type="checkbox"/> Arterial Puncture			♦ Collector:		
♦ Collection Date:			♦ Collection Facility/Lab:		
# Serum tubes _____ # Plasma tubes _____			Referring Lab: # of tubes sent _____ Samples shipped frozen <input type="checkbox"/>		
Fasting information <input type="checkbox"/> No <input type="checkbox"/> Yes # of hours _____					
Biochemistry			Therapeutic Drug Monitoring		
<input type="checkbox"/> Sodium NA/NAR	<input type="checkbox"/> C-Reactive Protein RCRP/CRP	<input type="checkbox"/> Carbamazepine CARB			
<input type="checkbox"/> Potassium K/KR	<input type="checkbox"/> Creatine Kinase CK	<input type="checkbox"/> Cyclosporine CY			
<input type="checkbox"/> Chloride CL/CLR	<input type="checkbox"/> Ferritin FER	<input type="checkbox"/> Digoxin DIG			
<input type="checkbox"/> Total CO ₂ /Bicarbonate CO ₂	<input type="checkbox"/> HCG Quantitative HCGQ	<input type="checkbox"/> Gentamicin GENT			
<input type="checkbox"/> Glucose [§] G	<input type="checkbox"/> HCG Qualitative (if HCGQ unavailable) HCGS	<input type="checkbox"/> Lithium LI			
<input type="checkbox"/> Creatinine CR	<input type="checkbox"/> Hemoglobin A1c GYHB	<input type="checkbox"/> Methotrexate MTX			
<input type="checkbox"/> eGFR EGFR	<input type="checkbox"/> Lactate LAC	<input type="checkbox"/> Mycophenolic acid MYPA			
<input type="checkbox"/> Urea U	<input type="checkbox"/> Lactate Dehydrogenase LD/LDH	<input type="checkbox"/> Phenobarbital PHEN			
<input type="checkbox"/> Calcium CA	<input type="checkbox"/> Lipase LIP/LIPA	<input type="checkbox"/> Phenytoin PYN			
<input type="checkbox"/> Total Protein TP	<input type="checkbox"/> Lipid Panel [§] LIPP	<input type="checkbox"/> Sirolimus SIRO			
<input type="checkbox"/> Albumin AL	<input type="checkbox"/> Triglycerides Only [§] TG	<input type="checkbox"/> Tacrolimus FKS			
<input type="checkbox"/> Bilirubin, Total TB	<input type="checkbox"/> Magnesium MG	<input type="checkbox"/> Tobramycin TOBR			
<input type="checkbox"/> Alanine Transaminase ALTR	<input type="checkbox"/> Osmolality OS	<input type="checkbox"/> Valproic acid VALP			
<input type="checkbox"/> Y-Glutamyl Transferase GGT	<input type="checkbox"/> Osmolality (Calculated) OSCA	<input type="checkbox"/> Vancomycin (Trough) VANC			
<input type="checkbox"/> Alkaline Phosphatase ALK/ALKP	<input type="checkbox"/> Phosphate P	TDM Dose info (must be completed): Last dose date/time: Next dose date/time:			
Blood Gases (pH, HCO₃, PCO₂, PO₂, and lactate)	<input type="checkbox"/> Troponin (method based on site) HTNT/TIWB				
<input type="checkbox"/> Arterial Blood Gas AGAS	<input type="checkbox"/> Uric Acid UA	Toxic Exposure			
<input type="checkbox"/> Venous Blood Gas VGAS	<input type="checkbox"/> %TSAT (incl. iron, TIBC) [§] IRON/IROR				
<input type="checkbox"/> Capillary Blood Gas CGAS					
<input type="checkbox"/> Mixed Blood Gas (from a line) MGAS					
<input type="checkbox"/> Umbilical Arterial Blood Gas UAGS					
<input type="checkbox"/> Umbilical Venous Blood Gas UVGS					
Hematology			Urinalysis		
<input type="checkbox"/> CBC (incl. differential) CBC	<input type="checkbox"/> Basic DIC Screen (PT/PTT/FIB/DDIMER/CBC) BASD	<input type="checkbox"/> Urinalysis (dipstick only) UR			
<input type="checkbox"/> Reticulocyte count RETA	<input type="checkbox"/> Sick Cell Screen HSS	<input type="checkbox"/> Urine Pregnancy Test PREG			
<input type="checkbox"/> Reticulocyte hemoglobin RETA	<input type="checkbox"/> Erythrocyte Sedimentation Rate ESR (Cannot be ordered with CRP unless approved)				
<input type="checkbox"/> HemoCue WBC IWBC	<input type="checkbox"/> Lupus Inhibitor LUPS				
<input type="checkbox"/> HemoCue HGB IHGB	<input type="checkbox"/> Fibrinogen CFIB				
<input type="checkbox"/> PT/INR PT/ IINR	<input type="checkbox"/> Infectious Mononucleosis MS				
Is patient on anticoagulant: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify):	<input type="checkbox"/> Malaria*** MAL (does not detect other blood micro-organisms; if suspected, check below)				
<input type="checkbox"/> D Dimer DDIM	<input type="checkbox"/> Other blood parasites*** BPNM				
<input type="checkbox"/> aPTT (**must indicate condition) APTT <input type="checkbox"/> Unfractionated Heparin <input type="checkbox"/> Liver Transplant <input type="checkbox"/> Cord blood <input type="checkbox"/> Other, please specify:	*** For Malaria and other non-malarial blood parasites, complete the following: Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No Recent travel history required: When: Where:				
Recommend hematology consult for unexplained bleeding					