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.

Biochemistry / Hematology Requisition

Clinics & Community – Outside Winnipeg and Brandon

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

Patient Preparation Instruction *(to be completed by ordering physician)*

§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	♦ 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	❑ Carbamazepine	CARB
❑	Potassium	K/KR	❑	Creatine Kinase	CK	❑ Cyclosporine	CY
❑	Chloride	CL/CLR	❑	Ferritin	FER	❑ Digoxin	DIG
❑	Total CO2/Bicarbonate	CO2	❑	HCG Quantitative	HCGQ	❑ Gentamicin Trough level	GENT
❑	Glucose §	G	❑	HCG Qualitative *(if HCGQ unavailable)*	HCGS	❑ Gentamicin Peak level	GEPK
❑	Creatinine *(+ eGFR if >18y)*	CR	❑	Hemoglobin A1c	GYHB	❑ Gentamicin Random level	RGEN
❑	Urea	U	❑	Lipid Panel §	LIPP	❑ Lithium	LI
❑	Calcium	CA	❑	Triglycerides only §	TG	❑ Methotrexate	MTX
❑	Total Protein	TP	❑	Magnesium	MG	❑ Mycophenolic acid	MYPA
❑	Albumin	AL	❑	Phosphate	P	❑ Phenobarbital	PHEN
❑	Bilirubin, Total	TB	❑	TSH Reflex *(will reflex Free T4/Free T3)*	TSH	❑ Phenytoin	PYN
❑	Alanine Transaminase	ALTR	❑	Uric Acid	UA	❑ Sirolimus	SIRO
❑	Y-Glutamyl Transferase	GGT	❑	Vitamin B12 §	B12	❑ Tacrolimus	FK5
❑	Alkaline Phosphatase	ALK/ ALKP	❑	%TSAT *(incl. iron, TIBC)* §	IRON/IROR	❑ Tobramycin Trough level	TOBR
			❑	NT-proBNP	NBNP	❑ Tobramycin Peak level	TOPK
Hematology						❑ Tobramycin Random level	RTOB
❑	CBC *(incl. differential)*	CBC	❑	Basic DIC Screen *(PT/PTT/FIB/DDIMER/CBC)*	BASD	❑ Valproic acid	VALP
❑	Reticulocyte count	RETA	❑	Sickle Cell Screen	HSS	❑ Vancomycin Trough level	VANC
❑	PT/INR	PT/ IINR	❑	Erythrocyte Sedimentation Rate *(cannot be ordered with CRP unless approved)*	ESR	❑ Vancomycin Peak level	VAPK
	Is patient on anticoagulant? ❑No ❑Yes *(specify):*					❑ Vancomycin Random level	RVAN
			❑	Lupus Inhibitor	LUPS	**TDM Dose info *(must be completed)*:**	
❑	D-Dimer	DDIM	❑	Infectious Mononucleosis	MS		
❑	Malaria** *(does not detect the presence of other blood parasites; if suspected, check the "Other blood parasites")*	MAL	** For Malaria and other non-malarial blood parasites, complete the following: **Fever?** ❑Yes ❑No *Recent travel history:* *When:* *Where:*			Last dose date/time: Next dose date/time:	
❑	Other blood parasites**	BPNM					

Additional Biochemistry /Hematology Tests	**Urinalysis & Other**	
	❑ Urinalysis (dipstick only)	UR
	❑ Urine Pregnancy Test	PREG
	❑ Group A Strep Antigen Testing *(use Clinical Microbiology requisition in Thompson)*	SATA