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:	*Critical Results Ph #:	* Date of Birth (dd/mm/yyyy)
*Facility Name/ Address		*Sex: □ Female □ 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: ❑ 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	GENT
❑	Glucose §	G	❑	HCG Qualitative *(if HCGQ unavailable)*	HCGS	❑ Lithium	LI
❑	Creatinine *(+ eGFR if >18y)*	CR	❑	Hemoglobin A1c	GYHB	❑ Methotrexate	MTX
❑	Urea	U	❑	Lipid Panel §	LIPP	❑ Mycophenolic acid	MYPA
❑	Calcium	CA	❑	Triglycerides only §	TG	❑ Phenobarbital	PHEN
❑	Total Protein	TP	❑	Magnesium	MG	❑ Phenytoin	PYN
❑	Albumin	AL	❑	Phosphate	P	❑ Sirolimus	SIRO
❑	Bilirubin, Total	TB	❑	TSH Reflex *(will reflex Free T4/Free T3)*	TSH	❑ Tacrolimus	FK5
❑	Alanine Transaminase	ALTR	❑	Uric Acid	UA	❑ Tobramycin	TOBR
❑	Y-Glutamyl Transferase	GGT	❑	Vitamin B12 §	B12	❑ Valproic acid	VALP
❑	Alkaline Phosphatase	ALK/ ALKP	❑	%TSAT *(incl. iron, TIBC)* §	IRON/IROR	❑ Vancomycin (Trough)	VANC

Hematology						**TDM Dose info *(must be completed)*:**
❑	CBC *(incl. differential)*	CBC	❑	Basic DIC Screen *(PT/PTT/FIB/DDIMER/CBC)*	BASD	Last dose date/time:
❑	Reticulocyte count	RETA	❑	Sickle Cell Screen	HSS	
❑	PT/INR	PT/ IINR	❑	Erythrocyte Sedimentation Rate *(cannot be ordered with CRP unless approved)*	ESR	Next dose date/time:
	Is patient on anticoagulant? ❑No ❑Yes *(specify):*		❑	Lupus Inhibitor	LUPS	**Urinalysis & Other**
❑	D Dimer	DDIM	❑	Infectious Mononucleosis	MS	❑ Urinalysis (dipstick only) UR
❑	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:*			❑ Urine Pregnancy Test PREG ❑ Group A Strep Antigen Testing SATA *(use Clinical Microbiology requisition in Thompson)*
❑	Other blood parasites**	BPNM				

Additional Biochemistry / Hematology Tests