

# Hospital Biochemistry / Hematology Requisition

For use in 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

<b>Ordering Provider Information</b>			<b>Patient Information (print or use addressograph)</b>		
*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		
<b>Copy Report To (if info missing, report may not be sent):</b>					
Last & Full First Name:	Ph #:	Fax #:	MRN:		
Facility Name/ Address:			Encounter #:		
Last & Full First Name:			Patient Ph #:		
Facility Name/ Address:			Patient Address:		
Last & Full First Name:			Demographics verified via:		
Facility Name/ Address:			<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other		

### Collection Information (fields marked with \* required by person collecting sample)

*Collection: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line	* Collector:	* Collection Date:
# Serum tubes _____ # Plasma tubes _____	* Collection Facility/Lab:	* Collection Time:
	Referring Lab: # of tubes sent _____	Samples shipped frozen <input type="checkbox"/>

### Biochemistry

<input type="checkbox"/> Sodium NA	<input type="checkbox"/> Creatine Kinase CK	<input type="checkbox"/> Osmolality OS
<input type="checkbox"/> Potassium K	<input type="checkbox"/> Total Protein TP	<input type="checkbox"/> Osmolality Calculated OSCA
<input type="checkbox"/> Chloride CL	<input type="checkbox"/> Albumin AL	<input type="checkbox"/> Ethanol ETO
<input type="checkbox"/> Total CO2 CO2	<input type="checkbox"/> Prealbumin PALB	<input type="checkbox"/> Lipase LIP
<input type="checkbox"/> Glucose G	<input type="checkbox"/> Troponin T HTNT	<input type="checkbox"/> Uric Acid UA
<input type="checkbox"/> Urea U	<input type="checkbox"/> Bilirubin, Total TB	<input type="checkbox"/> Myoglobin SMYO
<input type="checkbox"/> Creatinine CR	<input type="checkbox"/> Bilirubin, Direct DB	<input type="checkbox"/> Hemoglobin A1c GYHB
<input type="checkbox"/> eGFR eGFR	<input type="checkbox"/> Y-Glutamyl Transferase GGT	<input type="checkbox"/> Haptoglobin HPT
<input type="checkbox"/> Calcium CA	<input type="checkbox"/> Lactate Dehydrogenase LD	<input type="checkbox"/> C-Reactive Protein RCRP
<input type="checkbox"/> Phosphate P	<input type="checkbox"/> Alanine Transaminase ALT	<input type="checkbox"/> Ionized Calcium ICA
<input type="checkbox"/> Magnesium MG	<input type="checkbox"/> Alkaline Phosphatase ALK	<input type="checkbox"/> Ammonia (send on ice) AMM
<input type="checkbox"/> Lipid Panel LIPP	<input type="checkbox"/> Iron IRON	<input type="checkbox"/> Lactic Acid (send on ice) LAC
<input type="checkbox"/> Cholesterol only CH	<input type="checkbox"/> TIBC TIBC	<input type="checkbox"/> Beta-Hydroxybutyrate BHB
<input type="checkbox"/> Triglycerides only TG	<input type="checkbox"/> Ferritin FER	<input type="checkbox"/> HCG Quantitative HCGQ

### Drug Levels - Toxic Exposure/ Overdose

<input type="checkbox"/> Acetaminophen ACTM	<input type="checkbox"/> Alcohol Screen (incl methanol) ALC	<input type="checkbox"/> Ethylene glycol EGOL
<input type="checkbox"/> Carboxyhemoglobin CBHB	<input type="checkbox"/> Salicylate SAL	

### Therapeutic Drug Monitoring (complete dose/time info below)

<input type="checkbox"/> Carbamazepine CARB	<input type="checkbox"/> Cyclosporine CY	<input type="checkbox"/> Digoxin DIG
<input type="checkbox"/> Gentamicin GENT	<input type="checkbox"/> Lithium LI	<input type="checkbox"/> Methotrexate MTX
<input type="checkbox"/> Mycophenolic acid MYPA	<input type="checkbox"/> Phenobarbital PHEN	<input type="checkbox"/> Tacrolimus – FK506 FK5
<input type="checkbox"/> Phenytoin / (Dilantin) PYN	<input type="checkbox"/> Sirolimus SIRO	<input type="checkbox"/> Vancomycin VANC
<input type="checkbox"/> Tobramycin TOBR	<input type="checkbox"/> Valproic acid VALP	

Dose info: Last dose date/time: \_\_\_\_\_ Next dose date/time: \_\_\_\_\_

### Glucose Tolerance Testing

<input type="checkbox"/> 75 Gram Challenge (pregnancy) GTTP	<input type="checkbox"/> 50 Gram Challenge (pregnancy) GT50	<input type="checkbox"/> 75 Gram Challenge (non-pregnancy) GTT2
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### Hematology

<input type="checkbox"/> CBC (incl. differential) CBC	<input type="checkbox"/> Reticulocyte count RETA	<input type="checkbox"/> Reticulocyte hemoglobin RETA	<input type="checkbox"/> D Dimer DDIM
<input type="checkbox"/> PT/INR (indicate anticoagulant) INR	Is patient on anticoagulant: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____		
<input type="checkbox"/> Infectious Mononucleosis MS	<input type="checkbox"/> Erythrocyte Sedimentation Rate ESR	(Cannot be ordered with CRP unless approved)	
<input type="checkbox"/> Fibrinogen CFIB	<input type="checkbox"/> Lupus Inhibitor LUPS	<input type="checkbox"/> Sickle Cell Screen HSS	
<input type="checkbox"/> Basic DIC Screen (PT/PTT/FIB/DDIMER/CBC) BASD	<input type="checkbox"/> aPTT (*must indicate condition below) APTT	Recommend clinical hematology consult for unexplained bleeding	
	<input type="checkbox"/> Unfractionated Heparin	<input type="checkbox"/> Liver Transplant	<input type="checkbox"/> Cord blood <input type="checkbox"/> Other, please specify: _____
<input type="checkbox"/> Malaria** (does not detect other blood micro-organisms; if suspected, check below) MAL	<b>** For Malaria and other non-malarial blood parasites, complete the following:</b>		
<input type="checkbox"/> Other blood parasites** BPNM	Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>**Recent travel history required**</b>		
	<b>When: _____ Where: _____</b>		

Other Biochemistry/Hematology Tests (please list): \_\_\_\_\_