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

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	
*Last & Full First Name:	Billing Code:
*Inpatient Location/Facility Name/Address:	
Ph #	
*Critical Results Ph #:	Fax #:
Copy Report To *(if info missing, report may not be sent)*:	
Last & Full First Name: Ph #:	Fax #:
Facility Name/ Address:	
Last & Full First Name: Ph #:	Fax #:
Facility Name/ Address:	

Patient Information *(print or use addressograph)*
*Last/First Name: (per Health Card)

* Date of Birth (dd/mm/yyyy)

*Sex: □ Female □ Male
*PHIN: Specify Province or DND if different
MRN:
Encounter #:

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 ❑ 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					
❑ Sodium	NA	❑ Ferritin	FER	❑ Carbamazepine	CARB
❑ Potassium	K	❑ HCG Quantitative	HCGQ	❑ Cyclosporine	CY
❑ Chloride	CL	❑ %TSAT *(incl. iron, TIBC)* §	IRON	❑ Digoxin	DIG
❑ Total CO2/Bicarbonate	CO2	❑ Lactate	LAC	❑ Gentamicin Trough level	GENT
❑ Glucose§	G	❑ Lactate Dehydrogenase	LD	❑ Gentamicin Peak level	GEPK
❑ Creatinine	CR	❑ Lipase	LIP	❑ Gentamicin Random level	RGEN
❑ eGFR	EGFR	❑ Lipid Panel§	LIPP	❑ Lithium	LI
❑ Urea	U	❑ Triglycerides Only §	TG	❑ Methotrexate	MTX
❑ Calcium	CA	❑ Magnesium	MG	❑ Mycophenolic acid	MYPA
❑ Total Protein	TP	❑ Myoglobin	SMYO	❑ Phenobarbital	PHEN
❑ Albumin	AL	❑ Osmolality	OS	❑ Phenytoin	PYN
❑ Bilirubin, Total	TB	❑ Osmolality *(Calculated)*	OSCA	❑ Sirolimus	SIRO
❑ Alanine Transaminase	ALTR	❑ Phosphate	P	❑ Tacrolimus	FK5
❑ Y-Glutamyl Transferase	GGT	❑ Troponin T	HTNT	❑ Tobramycin Trough level	TOBR
❑ Alkaline Phosphatase	ALK	❑ NT-proBNP	NBNP	❑ Tobramycin Peak level	TOPK
❑ C-Reactive Protein	RCRP	❑ Uric Acid	UA	❑ Tobramycin Random level	RTOB
❑ Creatine Kinase	CK			❑ Valproic acid	VALP
Hematology				❑ Vancomycin Trough level	VANC
❑ CBC *(incl. differential)*	CBC	❑ Basic DIC Screen *(PT/PTT/FIB/DDIMER/CBC)*	BASD	❑ Vancomycin Peak level	VAPK
❑ Reticulocyte count	RETA	❑ Sickle Cell Screen	HSS	❑ Vancomycin Random level	RVAN
❑ Reticulocyte hemoglobin	CBC	❑ Erythrocyte Sedimentation Rate *(Cannot be ordered with CRP unless approved)*	ESR	**TDM Dose info *(must be completed)*:** Last dose date/time: Next dose date/time:	
❑ PT/INR	PT	❑ Lupus Inhibitor	LUPS		
Patient on anticoagulant: ❑No ❑ Yes *(specify)*:					
❑ D Dimer	DDIM	❑ Fibrinogen	CFIB	**Toxic Exposure**	
❑ aPTT *(**must indicate condition)*	APTT	❑ Infectious Mononucleosis	MS	❑ Ethanol	ETO
❑ Unfractionated Heparin ❑ Liver Transplant ❑Cord blood ❑Other, *please specify*:		❑ Malaria*** *(does not detect other blood micro-organisms; if suspected, check below)*	MAL	❑ Acetaminophen	ACTM
				❑ Salicylate	SAL
				❑ Ethylene Glycol ***(Sent to SBH)***	EGOL
Recommend hematology consult for unexplained bleeding		❑ Other blood parasites***	BPNM	❑ Volatile Screen ***(Sent to SBH)***	ALC

*** For Malaria and other non-malarial blood parasites, complete the following: **Fever?** ❑Yes ❑ No
Recent travel history required: When: *Where:*

Other Biochemistry/Hematology Tests