

Biochemistry / Hematology Requisition

Winnipeg/ Brandon Outpatient

Lab Use Only:
Place Barcode 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:		*Last/First Name: (per Health Card)	
Billing Code:		* Date of Birth (dd/mm/yyyy)	
Inpatient Location:	*Critical Results Ph #:	*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
*Facility Name/ Address		*PHIN: Specify Province or DND if different	
Ph #:	Fax #:	MRN:	
Copy Report To (if info missing, report may not be sent):			
Last & Full First Name:	Ph #:	Fax #:	
Facility Name/ Address:		Encounter #:	
Last & Full First Name:		Patient Ph #:	
Ph #:		Patient Address:	
Fax #:		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:
		♦ Collection Facility/Lab:	♦ Time:
# Serum tubes(s) _____	# Plasma tubes(p) _____	Referring Lab: # of tubes sent _____ Samples shipped frozen <input type="checkbox"/>	
Fasting information for glucose and lipid testing: Fasting 8-12 hours? <input type="checkbox"/> No <input type="checkbox"/> Yes # hours: _____			
Biochemistry			
<input type="checkbox"/> Sodium NA	<input type="checkbox"/> Total Protein TP	<input type="checkbox"/> Alanine Transaminase ALT	
<input type="checkbox"/> Potassium K	<input type="checkbox"/> Albumin AL	<input type="checkbox"/> Hemoglobin A1c GYHB/ HBA1	
<input type="checkbox"/> Chloride CL	<input type="checkbox"/> Y-Glutamyl Transferase GGT	<input type="checkbox"/> Iron IRON	
<input type="checkbox"/> Total CO2 CO2	<input type="checkbox"/> Alkaline Phosphatase ALK	<input type="checkbox"/> Total Iron Binding Capacity TIBC	
<input type="checkbox"/> Glucose G	<input type="checkbox"/> Creatine Kinase CK	<input type="checkbox"/> Ferritin FER	
<input type="checkbox"/> Urea U	<input type="checkbox"/> Lactate Dehydrogenase LD	<input type="checkbox"/> C-Reactive Protein RCRP	
<input type="checkbox"/> Creatinine CR	<input type="checkbox"/> Bilirubin, Total TB	<input type="checkbox"/> HCG Quantitative HCGQ	
<input type="checkbox"/> Calcium CA	<input type="checkbox"/> Bilirubin, Direct DB	<input type="checkbox"/> Vitamin B12 B12	
<input type="checkbox"/> Phosphate P	<input type="checkbox"/> Lipid Profile LIPP	<input type="checkbox"/> TSH (will reflex Free T4/Free T3) TSH	
<input type="checkbox"/> Magnesium MG	<input type="checkbox"/> Cholesterol Only CH		
<input type="checkbox"/> Uric Acid UA	<input type="checkbox"/> Triglycerides Only TG		
Therapeutic Drug Monitoring (complete dose 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 (list for all): 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	
Hematology			
<input type="checkbox"/> CBC with Differential CBC	<input type="checkbox"/> Reticulocyte count RETA	<input type="checkbox"/> Sickle Cell Screen HSS	
<input type="checkbox"/> PT/INR PT	Is patient on anticoagulant? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify):		
<input type="checkbox"/> Erythrocyte Sedimentation Rate ESR	(cannot be ordered with CRP unless approved)		
<input type="checkbox"/> Basic DIC Screen BASD	Incl. PT/PTT/FIB/DDIMER/CBC		<input type="checkbox"/> D Dimer DDIM
			<input type="checkbox"/> Infectious Mononucleosis MS
			<input type="checkbox"/> Lupus Inhibitor LUPS
<input type="checkbox"/> Malaria** (does not detect the presence of other blood parasites; if suspected, check the "Other blood parasites" box) MAL		** For Malaria and other non-malarial blood parasites, complete the following: When: Where:	
<input type="checkbox"/> Other blood parasites** BPNM		Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Biochemistry/Hematology Tests:			