

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

Clinic & Community – 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

<b>Ordering Provider Information</b>			<b>Patient Information</b> <i>(print or use addressograph)</i>			
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)			
Inpatient Location:		*Critical Results Ph #:				
*Facility Name/ Address						
Ph #:		Fax #:				
<b>Copy Report To</b> <i>(if info missing, report may not be sent):</i>						
Last & Full First Name:		Ph #:	Fax #:			
Facility Name/ Address:						
Last & Full First Name:		Ph #:	Fax #:			
Facility Name/ Address:						
Demographics verified via:			<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other			
<b>Patient Preparation Instruction</b> <i>(to be completed by ordering physician)</i>						
§Fast <i>(nothing to eat, drink or chew)</i> for: <input type="checkbox"/> 8-12h <input type="checkbox"/> Alternate time ____h <input type="checkbox"/> Fasting not required <i>(if not checked, assume fasting not required)</i>						
<b>Collection Information</b> <i>(fields marked with ♦ required by person collecting sample)</i>						
♦Collection:		♦ Collector:		♦ Collection Date:		
<input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line		♦ Collection Facility/Lab:		♦ Collection Time:		
# Serum tubes(s) ____		# Plasma tubes(p) ____		Referring Lab: # of tubes sent ____   Samples shipped frozen <input type="checkbox"/>		
Fasting information <input type="checkbox"/> No <input type="checkbox"/> Yes   # of hours ____						
<b>Biochemistry</b>			<b>Therapeutic Drug Monitoring</b>			
<input type="checkbox"/> Sodium	NA	<input type="checkbox"/> C-Reactive Protein	RCRP	<input type="checkbox"/> Carbamazepine	CARB	
<input type="checkbox"/> Potassium	K	<input type="checkbox"/> Creatine Kinase	CK	<input type="checkbox"/> Cyclosporine	CY	
<input type="checkbox"/> Chloride	CL	<input type="checkbox"/> Ferritin	FER	<input type="checkbox"/> Digoxin	DIG	
<input type="checkbox"/> Total CO2/Bicarbonate	CO2	<input type="checkbox"/> HCG Quantitative	HCGQ	<input type="checkbox"/> Gentamicin	GENT	
<input type="checkbox"/> Glucose <sup>§</sup>	G	<input type="checkbox"/> Hemoglobin A1c	GYHB	<input type="checkbox"/> Lithium	LI	
<input type="checkbox"/> Creatinine (+ eGFR if >18y)	CR	<input type="checkbox"/> Lipid Panel <sup>§</sup>	LIPP	<input type="checkbox"/> Methotrexate	MTX	
<input type="checkbox"/> Urea	U	<input type="checkbox"/> Triglycerides only <sup>§</sup>	TG	<input type="checkbox"/> Mycophenolic acid	MYPA	
<input type="checkbox"/> Calcium	CA	<input type="checkbox"/> Magnesium	MG	<input type="checkbox"/> Phenobarbital	PHEN	
<input type="checkbox"/> Total Protein	TP	<input type="checkbox"/> Phosphate	P	<input type="checkbox"/> Phenytoin	PYN	
<input type="checkbox"/> Albumin	AL	<input type="checkbox"/> TSH Reflex <i>(will reflex Free T4/Free T3)</i>	TSH	<input type="checkbox"/> Sirolimus	SIRO	
<input type="checkbox"/> Bilirubin, Total	TB	<input type="checkbox"/> Uric Acid	UA	<input type="checkbox"/> Tacrolimus	FK5	
<input type="checkbox"/> Alanine Transaminase	ALTR	<input type="checkbox"/> Vitamin B12 <sup>§</sup>	B12	<input type="checkbox"/> Tobramycin	TOBR	
<input type="checkbox"/> Y-Glutamyl Transferase	GGT	<input type="checkbox"/> %TSAT <i>(incl. iron, TIBC)</i> <sup>§</sup>	IRON	<input type="checkbox"/> Valproic acid	VALP	
<input type="checkbox"/> Alkaline Phosphatase	ALK			<input type="checkbox"/> Vancomycin (Trough)	VANC	
<b>Hematology</b>			<b>TDM Dose info</b> <i>(must be completed):</i>  Last dose date/time:  Next dose date/time:			
<input type="checkbox"/> CBC <i>(incl. differential)</i>	CBC	<input type="checkbox"/> Basic DIC Screen <i>(PT/PTT/FIB/DDIMER/CBC)</i>				BASD
<input type="checkbox"/> Reticulocyte count	RETA	<input type="checkbox"/> Sickie Cell Screen				HSS
<input type="checkbox"/> PT/INR	PT	<input type="checkbox"/> Erythrocyte Sedimentation Rate				ESR
Is patient on anticoagulant? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(specify):</i>		<input type="checkbox"/> Lupus Inhibitor				LUPS
<input type="checkbox"/> D Dimer	DDIM	<input type="checkbox"/> Infectious Mononucleosis	MS			
<input type="checkbox"/> Malaria**	MAL	** For Malaria and other non-malarial blood parasites, complete the following: <b>Fever?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>Recent travel history:</i> When: Where:				
<input type="checkbox"/> Other blood parasites**	BPNM					
<b>Additional Biochemistry/Hematology Tests</b>						