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**

| **Ordering Provider Information** | | |
|---|---|---|
| *Last & Full First Name: | | Billing Code: |
| Inpatient Location: | *Critical Results Ph #: | |
| *Facility Name/ Address | | |
| 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 #:
Patient Ph #:

Patient 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(s) ____ # Plasma tubes(p) ____ | Referring Lab: # of tubes sent _____ | Samples shipped frozen ❑ |

Fasting information ❑ **No** ❑ **Yes** **# of hours**_____

| **Biochemistry** | | | | **Therapeutic Drug Monitoring** | |
|---|---|---|---|---|---|
| ❑ Sodium | NA | ❑ C-Reactive Protein | RCRP | ❑ Carbamazepine | CARB |
| ❑ Potassium | K | ❑ Creatine Kinase | CK | ❑ Cyclosporine | CY |
| ❑ Chloride | CL | ❑ Ferritin | FER | ❑ Digoxin | DIG |
| ❑ Total CO2/Bicarbonate | CO2 | ❑ HCG Quantitative | HCGQ | ❑ Gentamicin Trough level | GENT |
| ❑ Glucose§ | G | ❑ Hemoglobin A1c | GYHB | ❑ Gentamicin Peak level | GEPK |
| ❑ Creatinine *(+ eGFR if >18y)* | CR | ❑ Lipid Panel§ | LIPP | ❑ Gentamicin Random level | RGEN |
| ❑ Urea | U | ❑ Triglycerides only§ | TG | ❑ Lithium | LI |
| ❑ Calcium | CA | ❑ Magnesium | MG | ❑ Methotrexate | MTX |
| ❑ Total Protein | TP | ❑ Phosphate | P | ❑ Mycophenolic acid | MYPA |
| ❑ Albumin | AL | ❑ TSH Reflex *(will reflex Free T4/Free T3)* | TSH | ❑ Phenobarbital | PHEN |
| ❑ Bilirubin, Total | TB | ❑ Uric Acid | UA | ❑ Phenytoin | PYN |
| ❑ Alanine Transaminase | ALTR | ❑ Vitamin B12§ | B12 | ❑ Sirolimus | SIRO |
| ❑ Y-Glutamyl Transferase | GGT | ❑ %TSAT *(incl. iron, TIBC)* § | IRON | ❑ Tacrolimus | FK5 |
| ❑ Alkaline Phosphatase | ALK | ❑ NT-proBNP | NBNP | ❑ Tobramycin Trough level | TOBR |
| **Hematology** | | | | ❑ Tobramycin Peak level | TOPK |
| ❑ CBC *(incl. differential)* | CBC | ❑ Basic DIC Screen *(PT/PTT/FIB/DDIMER/CBC)* | BASD | ❑ Tobramycin Random level | RTOB |
| ❑ Reticulocyte count | RETA | ❑ Sickle Cell Screen | HSS | ❑ Valproic acid | VALP |
| ❑ PT/INR | PT | ❑ Erythrocyte Sedimentation Rate | ESR | ❑ Vancomycin Trough level | VANC |
| Is patient on anticoagulant? ❑ No ❑ Yes *(specify):* | | *(Cannot be ordered with CRP unless approved)* | | ❑ Vancomycin Peak level | VAPK |
| | | ❑ Lupus Inhibitor | LUPS | ❑ Vancomycin Random level | RVAN |
| ❑ D-Dimer | DDIM | ❑ Infectious Mononucleosis | MS | **TDM Dose info *(must be completed)*:** | |
| ❑ 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:* | | Last dose date/time: Next dose date/time: | |
| ❑ Other blood parasites** | BPNM | | | | |

**Other Biochemistry/Hematology Tests**