

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.

# Endocrinology Requisition

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> (print or use addressograph)	
*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: <span style="float: right;">*Specify Province or DND if different</span>
<b>Copy Report To</b> (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:			
Demographics verified via: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other			
<b>COLLECTION INFORMATION</b> (fields marked with ♦ required by person collecting sample) <b>No biotin &gt;5mg/day 8 hours prior to collection</b>			
♦ Collector:		♦ Collection Date:	
♦ Collection Facility/Lab:		♦ Collection Time:	
		♦ Collected Via: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line	
# Serum vial(s) _____ # Plasma vials (p) _____		Referring Lab: Number of tubes sent _____	
		Samples shipped frozen <input type="checkbox"/>	
<b>Relevant Medications (check all that apply)</b> <input type="checkbox"/> Thyroxine <input type="checkbox"/> Oral Contraceptives <input type="checkbox"/> Methimazole <input type="checkbox"/> Amiodarone <input type="checkbox"/> Other: Specify:			
<b>Thyroid Hormone Testing</b>		<b>Other Endocrine Testing</b>	
<b>Androgen Testing</b> <sup>3</sup> Must be completed or testing will not be performed			
<input type="checkbox"/> Thyroid Reflex Testing (Screening for thyroid disease, will reflex FT4 and/ or FT3 if TSH abnormal) TSH	<input type="checkbox"/> ACTH (see LIM <sup>2</sup> for collection & transport) ACTH	<input type="checkbox"/> Testosterone <sup>3</sup> TST (AM recommended. Lab adds albumin on males over 17)	
<input type="checkbox"/> Thyroperoxidase Antibodies TPO	<input type="checkbox"/> Cortisol <sup>2</sup> <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Other COR	<input type="checkbox"/> DHEA-S <sup>3</sup> DHAS	
<input type="checkbox"/> TSH Receptor Antibody TRAB	<input type="checkbox"/> Aldosterone ALDO	<input type="checkbox"/> Sex Hormone-Binding Globulin <sup>3</sup> SHBG	
<input type="checkbox"/> Thyroglobulin (Anti-thyroglobulin automatically performed) THGL	<input type="checkbox"/> Renin (Order ALDO + REN to get ratio) REN	<input type="checkbox"/> Free Androgen Index <sup>3</sup> FAI	
<input type="checkbox"/> Free T4 <sup>1</sup> FT4	<input type="checkbox"/> Growth Hormone (for concurrent hypoglycemia) GH	<b>Indications for Androgen Testing<sup>3</sup></b> Must be completed or testing will not be performed <b>Necessary for Clinical Correlation of results</b>	
<b>Indications for Free T4<sup>1</sup></b> Must be completed or testing will not be performed	<input type="checkbox"/> Insulin INS	<ul style="list-style-type: none"> <li>• Infertility</li> <li>• Hirsutism</li> <li>• Virilization</li> <li>• Amenorrhea</li> <li>• Oligomenorrhea</li> <li>• Hypogonadism</li> <li>• Erectile Dysfunction</li> <li>• Precocious Puberty</li> <li>• Delayed Puberty</li> <li>• Testicular or adrenal tumor</li> <li>• Testosterone Replacement Therapy</li> <li>• Antiandrogen therapy</li> <li>• Hormone replacement therapy</li> </ul> Specify	
<ul style="list-style-type: none"> <li>• Hyperthyroid</li> <li>• Hypothyroid</li> <li>• Hypopituitarism</li> <li>• Goiter</li> <li>• Thyroiditis</li> <li>• Autoimmune Disease</li> <li>• Thyroxine Replacement Therapy</li> <li>• Thyroid Cancer Suppression</li> <li>• Malabsorption</li> <li>• Other (must be specified)</li> </ul> Specify:	<input type="checkbox"/> Creatinine CR		
	<input type="checkbox"/> Parathyroid Hormone (must have previous abnormal Creatinine or Calcium) PTH		
	<input type="checkbox"/> Calcium CA		
	<input type="checkbox"/> Folicle Stimulating Hormone FSH		
	<input type="checkbox"/> Luteinizing Hormone LH		
	<input type="checkbox"/> Prolactin PL		
	<input type="checkbox"/> Estradiol E2		
	<input type="checkbox"/> 17-Hydroxyprogesterone PR17		
	<input type="checkbox"/> Progesterone PGN		
<input type="checkbox"/> HCG (Quantitative) HCGQ			
Other Information			
<b>*Signature of Ordering Provider:</b>		<b>LAB USE ONLY FOR BARCODE PLACEMENT</b>	

<sup>2</sup> Complete collection information can be found in the Lab Information Manual (LIM) at <https://apps.sbgf.mb.ca/labmanual/test/findTestPrepare>