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Ship samples to:
St/ Boniface Hospital Hematology Lab
L4006-409 Tache Ave
Winnipeg, MB R2H 2A6
Phone: 204-237-2468
Fax: 204-237-2494

Hemoglobinopathy Investigation Requisition

This space for lab use only
Place DELPHIC Label here

Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection.

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION
***Last & Full First Name:**		*Last/First Name: (per MB Health Card)
Billing Code:	**Inpatient Location:**	* Date of Birth (dd/mm/yyyy)
***Facility Name/Address**		*Sex: Female Male
Phone No:	**Fax No:**	*PHIN:
Critical Results Phone Number:		*Specify Province or DND if different
COPY REPORT TO: (if info missing, report may not be sent)		MRN:
Last & Full First Name:	**Fax No:**	Encounter Number:
Facility Name/Address:	**Phone No:**	Patient Phone Number:
Last & Full First Name:	**Fax No:**	Patient Address:
Facility Name/Address:	**Phone No:**	Demographics verified: ❑ Prov. Health Card ❑ Armband ❑ eChart/CR

Collection Information Fields marked with "♦"required by person collecting sample		
♦**Collector:**	♦**Collection Date:**	♦Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Above shut off IV
♦**Collection Facility/Lab:**	♦**Collection Time:**	
# Serum vial(s) ____ # Plasma vials(p)	Referring Lab: # of tubes sent ____	Samples shipped frozen ❑

Testing <u>WILL NOT</u> be initiated unless ALL of the items/questions regarding clinical information and family history are answered.

Ethnicity _____

Previously tested: ☐ **No** ☐ **Yes**

Pre-existing diagnosis: ☐ **No** ☐ **Yes** **If yes, list: _____**

Medication(s): ☐ **No** ☐ **Yes** **If yes, list: _____**

Red cell transfusion in last 3 months: ☐ **No** ☐ **Yes** **Date: _____** **(DD/MM/YYYY)**

Is patient pregnant? ☐ **No** ☐ **Yes**

Is partner pregnant? ☐ **No** ☐ **Yes**

Has partner been tested? ☐ **No** ☐ **Yes** **Name: _____** **(Last)** **_____** **(First)**

Family members with hemoglobinopathy ☐ **No** ☐ **Yes** **If yes, Name(s)/Relation: _____**

_____ _____

TEST	**SAMPLES REQUIRED**	**TEST CODE**
☐ **HEMOGLOBINOPATHY INVESTIGATION**	**<u>Blood for Hemoglobin Electrophoresis</u>:** **Neonate: 3 EDTA Microtainers only** **Pediatric: 3 EDTA Microtainers; 2 Li Heparin/Serum Microtainers** **Adult: 2–4 mL EDTA; 4 mL Li Heparin/Serum**	**HEL/CBC** **FER**

Instructions to Laboratories:
**** If CBC/ferritin processed on site, send a freshly made unstained peripheral blood film and a copy of the CBC/ Ferritin results with the Hemoglobin Electrophoresis sample.**
***** SAMPLES FOR HEMOGLOBIN ELECTROPHORESIS MUST BE LESS THAN 5 DAYS FROM COLLECTION.**

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