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.

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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>:**<br>**Neonate: 3 EDTA Microtainers only**<br>**Pediatric: 3 EDTA Microtainers; 2 Li Heparin/Serum Microtainers**<br>**Adult: 2–4 mL EDTA; 4 mL Li Heparin/Serum** | **HEL/CBC**<br>**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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