

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.

**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: <input type="checkbox"/> Prov. Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR
Collection Information Fields marked with "*" required by person collecting sample		
*Collector:	*Collection Date:	*Collection: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line
*Collection Facility/Lab:	*Collection Time:	<input type="checkbox"/> Above shut off IV
# Serum vial(s) _____ # Plasma vials(p) _____	Referring Lab: # of tubes sent _____	Samples shipped frozen <input type="checkbox"/>

Testing **WILL NOT** 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
<input type="checkbox"/> HEMOGLOBINOPATHY INVESTIGATION	<b>Blood for Hemoglobin Electrophoresis:</b> 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.