

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.

THIS SPACE FOR LAB USE ONLY:
PLACE LIS LABEL HERE:

BONE MARROW TRIAGE CONFIRMATION REQUISITION

THIS SPACE FOR LAB USE ONLY:
PLACE HMD LABEL HERE:

Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection

Ordering Provider Information		Patient Information <i>(print or use addressograph)</i>	
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)
*Inpatient Location/Facility Name/Address:		* Date of Birth (dd/mm/yyyy)	
Ph #		*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Critical Results Ph #:		*PHIN: Specify Province or DND if different	
Fax #:		MRN:	
Copy Report To <i>(if info missing, report may not be sent):</i>			
Last & Full First Name:	Ph #:	Fax #:	Encounter #:
Facility Name/ Address:		Demographics verified via:	
Last & Full First Name:		<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other	
Ph #:			
Fax #:			
Facility Name/ Address:			
COLLECTION INFORMATION <i>(fields marked with ♦ required by person collecting sample)</i>			
♠Collector:	♠Collection Date:	♠Collection Facility/Lab:	♠Collection Time:
Additional Samples collected prior to Triage:	Site Log/File Number (HSC):	Previous Bone Marrow(s)	
	_____	<input type="checkbox"/> Yes (attached) <input type="checkbox"/> No	
Immunophenotyping (Flow)	Requested by Hematopathologist <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Collected <input type="checkbox"/> Not collected	Instructions:		
Cytogenetics	Requested by Hematopathologist <input type="checkbox"/> Process <input type="checkbox"/> Fix only <input type="checkbox"/> No		
<input type="checkbox"/> Collected <input type="checkbox"/> Not collected	Instructions:		
FISH	Requested by Hematopathologist <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Collected <input type="checkbox"/> Not collected	Instructions:		
Molecular Studies	Requested by Hematopathologist <input type="checkbox"/> Yes <input type="checkbox"/> Secure and Store <input type="checkbox"/> No		
<input type="checkbox"/> Collected <input type="checkbox"/> Not collected	Instructions:		
Total # of biopsies: _____	Process for: <input type="checkbox"/> Histology <input type="checkbox"/> Cytogenetics <input type="checkbox"/> Flow <input type="checkbox"/> Molecular		
Formalin: _____ RPMI/saline: _____	Cutting instruction: _____		
Slide available for iron: <input type="checkbox"/> Yes <input type="checkbox"/> No		Process: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Triaged by: _____

Date/Time: _____