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:

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 with: ❑ Prov. Health Card ❑ Armband ❑ eChart/CR

COLLECTION INFORMATION (fields marked with ♦ required by person collecting sample)			
♦Collector:	**♦Collection Date:**	**♦Collection Facility/Lab:**	**♦Collection Time:**

Site Log/File number (HSC): _____

Immunophenotyping (Flow)	Requested by Hematopathologist ❑ Yes ❑ No
❑ Collected ❑ Not collected	Instructions:
Cytogenetics	Requested by Hematopathologist ❑ Process ❑ Fix only ❑ No
❑ Collected ❑ Not collected	Instructions:

Total # of biopsies: _____	Process for: ❑ Histology ❑ Cytogenetics ❑ Flow ❑ Molecular
in formalin: _____	
in RPMI/saline: _____	Cutting instruction: _____

Slide available for iron: ❑ Yes ❑ No **Process:** ❑ Yes ❑ No

Fish	Requested by Hematopathologist ❑ Yes ❑ No
❑ Collected ❑ Not collected	Instructions:

Molecular Studies	Requested by Hematopathologist ❑ Yes ❑ Secure and Store ❑ No
❑ Collected ❑ Not collected	Instructions:

Triaged by: _____ Date/Time: _____

Shared health Soins communs Manitoba

Approval Date: 11-JAN-2023
R250-10-101 V01

SAP # 395115