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.

Molecular Diagnostic Laboratory – Out of Center Genetic Test Requisition

Deliver all specimens to:
Health Sciences Centre - Central Services
MS551-820 Sherbrook Street
Winnipeg, Manitoba R3A 1R9

For specimen requirements and test information contact:
MDL Telephone: 204-787-1024
Lab Fax: 204-787-1384
SHIP SAMPLES AT ROOM TEMPERATURE

Additional requisitions & sample requirements at:
Lab Information Manual (sbgh.mb.ca)
https://apps.sbgh.mb.ca/labmanual/

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** ***(print or use addressograph)***
*Last & Full First Name:	Billing Code:	*Last/First Name: (per Health Card)
Inpatient Location:	Critical Results Ph #:	* Date of Birth (dd/mm/yyyy)
*Facility Name/ Address		*Biological Sex: □ Female □ Male
*Ph #:	*Fax #:	*PHIN: Specify Province or DND if different
Copy Report To (if info missing, report may not be sent):		
Last & Full First Name:	Billing Code:	MRN:
Ph #:	Fax #:	Encounter #:
Facility Name/ Address:		Patient Ph #:
Clinic Contact:		Patient Address:
		Demographics verified via: ☐ Health Card ☐ Armband ☐ eChart/CR ☐ Other

Collection Information (fields marked with ☐ required by person collecting sample)

☐ Collector:	☐ Collection Date:	Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Other:
☐ Collection Facility/Lab:	☐ Time:	

Test Requested See LIM for details https://apps.sbgh.mb.ca/labmanual/	**Sample Information** Samples labeled with 2 patient identifiers	**Reason for Testing**
☐ Out-of-Center Testing **MD**	**Is patient bone marrow recipient? □ Yes □ No**	☐ Confirmation of suspected clinical diagnosis
Test name: _____	☐ Blood 2x4mL EDTA (preferred)	☐ Carrier status
	☐ DNA	☐ Predictive testing
Test code (if available): _____	☐ Other: _____	☐ Familial segregation analysis
Referral Laboratory: _____		☐ Prenatal Diagnosis (Genetics Only) EDC: _____
		☐ Other: _____

Required Test Request Information Testing will **NOT** be initiated without this information.

URGENT request? ☐ **No** ☐ **Yes** If yes, select reason:	☐ Results will alter the immediate management and/or treatment of this patient ☐ Results will impact an ongoing pregnancy (provide EDD, and procedure date if applicable):

Suspected Diagnosis and Clinical Features
Additional supporting information such as clinic letters, pedigree, diagnostic and imaging reports, may be required and requested.

Family History
Has anyone else in the family had previous genetic testing for this condition?
☐ No ☐ Yes If yes, complete below and provide a copy the index patient's report.

Index patient name:	Relationship to patient:	Referral laboratory:

A positive molecular test result will:

1. Change therapy or clinical management of:
   This patient? ☐ **No** ☐ **Yes** Family member? ☐ **No** ☐ **Yes**
2. Stop further clinical investigations for the patient?
   ☐ **No** ☐ **Yes**
3. Impact reproductive risk of patient and at-risk relatives?
   ☐ **No** ☐ **Yes**
4. Impact an ongoing pregnancy?
   ☐ **No** ☐ **Yes**

Direct inquiries regarding use of this requisition to the Laboratory Genetic Counsellor (Ph: 204-787-4033; Fax: 204-787- 2563; email GenomicslabGC@sharedhealthmb.ca)

Shared health Soins communs Manitoba