

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

Additional requisitions & sample requirements at:

[Lab Information Manual \(sbgh.mb.ca\)](https://apps.sbggh.mb.ca/labmanual/)
<https://apps.sbggh.mb.ca/labmanual/>

SHIP SAMPLES AT ROOM TEMPERATURE

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:		*Last/First Name: (per Health Card)	
Inpatient Location:	Critical Results Ph #:	* Date of Birth (dd/mm/yyyy)	
*Facility Name/ Address		*Biological Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
*Ph #:	*Fax #:	*PHIN: Specify Province or DND if different	
Copy Report To (if info missing, report may not be sent):		MRN:	
Last & Full First Name:		Encounter #:	
Ph #:	Fax #:	Patient Ph #:	
Facility Name/ Address:		Patient Address:	
Clinic Contact:		Demographics verified via: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other	
Collection Information (fields marked with <input type="checkbox"/> required by person collecting sample)			
<input type="checkbox"/> Collector:	<input type="checkbox"/> Collection Date:	Collection: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary	
<input type="checkbox"/> Collection Facility/Lab:	<input type="checkbox"/> Time:	<input type="checkbox"/> Indwelling Line <input type="checkbox"/> Other:	
Test Requested	Sample Information	Reason for Testing	
See LIM for details https://apps.sbggh.mb.ca/labmanual/	Samples labeled with 2 patient identifiers		
<input type="checkbox"/> Out-of-Center Testing MD Test name: _____ Test code (if available): _____ Referral Laboratory: _____	Is patient bone marrow recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Blood 2x4mL EDTA (preferred) <input type="checkbox"/> DNA <input type="checkbox"/> Other: _____	<input type="checkbox"/> Confirmation of suspected clinical diagnosis <input type="checkbox"/> Carrier status <input type="checkbox"/> Predictive testing <input type="checkbox"/> Familial segregation analysis <input type="checkbox"/> Prenatal Diagnosis (Genetics Only) EDC: _____ <input type="checkbox"/> Other: _____	
Required Test Request Information Testing will NOT be initiated without this information.			
URGENT request? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, select reason:		<input type="checkbox"/> Results will alter the immediate management and/or treatment of this patient <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes Family member? <input type="checkbox"/> No <input type="checkbox"/> Yes		3. Impact reproductive risk of patient and at-risk relatives? <input type="checkbox"/> No <input type="checkbox"/> Yes	
2. Stop further clinical investigations for the patient? <input type="checkbox"/> No <input type="checkbox"/> Yes		4. Impact an ongoing pregnancy? <input type="checkbox"/> No <input type="checkbox"/> 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)