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.

URINE and MICROBIOLOGY REQUISITION/REPORT

Acceptance Policy 10-50-03 - Requirements for Test Requisitions 2.1 - All information marked with an * is mandatory and must be clearly legible. Failure to comply may result in specimen rejection.

ORDERING PROVIDER INFORMATION	
* Last & Full First Name:	Billing Code:
* Ordering Facility:	Inpatient Location:
Address:	
Critical Results Phone Number:	Fax No.:

COPY REPORT TO: (if needed info missing, report may not be sent)	
Last & Full First Name:	Fax No:
Facility Name/Address:	Phone No:
Last & Full First Name:	Fax No:
Facility Name/Address:	Phone No:

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

PATIENT INFORMATION

*Last/First Name:
(per MB. Health Card)

* Date of Birth
(dd/mm/yyyy)

*Sex: Female Male

*PHIN:

Specify if other Province or DND

MRN:

Encounter Number:

Patient Phone No.:

Patient Address:

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

TEST	REFERENCE RANGE
Urinalysis Dipstick	
Glucose	Negative
Bilirubin	Negative
Ketones	Negative
Specific Gravity	1.005 - 1.030
Blood	Negative
pH	5.0 - 8.0
Protein	Negative
Urobilinogen	3 - 16 umol/L
Nitrate	Negative
Leukocytes	Negative

PLACE

PRINT-OUT

HERE

TEST	CONTROL RESULT (Circle one)	RESULT Pos/Neg
Pregnancy Test	Pass / Fail	
Group A Strep Antigen Detection	Pass /Fail	
Monospot Report	Pass/Fail	

Reported by: _____ **Date:** _____