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.

DIAGNOSTIC SERVICES MANITOBA | SERVICES DIAGNOSTIC MANITOBA

Molecular Diagnostic Laboratory Requisition

Please have all specimens delivered to:
Health Sciences Centre-Central Services
MS551- 820 Sherbrook St
Winnipeg, Manitoba R3A 1R9

For specimen requirements and test information contact:
MDL Telephone: 204-787-1024
Lab Fax: 204-787-3846
Call Centre (24 hr): 204-787-1534
SHIP SAMPLES AT ROOM TEMPERATURE

Additional requisitions and sample requirements available at:
www.dsmanitoba.ca /Medical Practitioners / LIM

*** Fields marked with an asterisk are mandatory and must be clearly legible. Failure to comply may result in specimen rejection (see DSM policy 10-50-03).**

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION	
***Last & Full First Name:**	**Billing Code:**	***Last/First Name:** (as per Manitoba Health Card)	
***Ordering Facility:**	**Inpatient Location:**	***Date of Birth:** (dd/mm/yyyy)	**Address:**
Address:		***Biological Sex:** ☐ Female ☐ Male	
***Critical Results Phone No:**	***Fax No.**	***PHIN:**	
ADDITIONAL COPY OF REPORT (FOR MANITOBA PHYSICIANS ONLY)		***Alternate ID:** (include ID type with number i.e. RCMP, SK, DND, etc.)	***Phone No:**
***Last & Full First Name:**	**Billing Code:**		
***Facility Name:**		**MHSC#:**	**MRN:**
Address:		**Encounter Number:**	
Phone No:	***Fax No.**	**Demographics verified with:**	☐ Health Card ☐ eChart/CR ☐ Armband

CONTACT INFO		COLLECTION INFORMATION
Clinic/Laboratory Contact Name:_____	***Collector:**	***Collection Time:** (hh:mm)
Clinic/Laboratory Contact Telephone No :_____	***Collection Date:** (dd/mm /yyyy)	***Collection Facility/Lab:**

I. Test Requested

See website for test details, guidelines and sample requirements
https://apps.sbgh.mb.ca/labmanual/

- ☐ Angelman Syndrome MD
- ☐ APOE MD
- ☐ Ashkenazi Jewish Panel (ASPA, HEXA, IKBKAP, FANCC) MD
- ☐ Charcot-Marie-Tooth type 1A MD
- ☐ Cystic Fibrosis/ CFTR-related disorders (ethnic background required) MD
- ☐ DNA banking MD
- ☐ Familial Hypertrophic Cardiomyopathy(Mennonite mutation)MD
- ☐ Fragile X/ FMR1- related disorders MD
- ☐ Hemochromatosis (transferrin saturation required) MD
- ☐ Hereditary Neuropathy with Liability to Pressure Palsies MD
- ☐ HNF1α (Aboriginal mutation) MD
- ☐ Huntington disease MD
- ☐ Hypophosphatasia (Mennonite mutation) MD
- ☐ Kennedy disease MD
- ☐ Myotonic Dystrophy Type 1(ethnic background required) MD
- ☐ Non-Syndromic Deafness (GJB2 and GJB6) (ethnic background required) MD
- ☐ Oculopharyngeal Muscular Dystrophy MD
- ☐ Prader-Willi Syndrome MD
- ☐ Spinal Muscular Atrophy (referred out) MD
- ☐ Spinocerebellar ataxia types 1,2,3,6,7,8 MD
- ☐ Thalassemia (ethnic background required) MD
- ☐ Yq microdeletion MD
- ☐ Other (includes referred out testing)

_____ MD

_____

Samples Required

Samples must be labeled with patient name and PHN or equivalent

- ☐ Blood 2x 4 mL EDTA
- ☐ Blood (infant only) 0.5-2 mL EDTA
- ☐ DNA 15 µg
  Minimum concentration 150ng/µL

For other Sample Types:

- ☐ Cultured Amniocytes ◊
- ☐ Amniotic Fluid ◊ 4-10 mL
- ☐ Tissue
  Pathology Reference No.

_____

- ☐ Other _____

◊ Contact lab prior to ordering.
Sample volumes may vary.

Delphic Barcode Label

II. Reason for Test

May require prior genetic consultation before testing.

Is this patient or patient's partner pregnant?
☐ No ☐ Yes LMP:_____

- ☐ Confirmation of Clinical Diagnosis
- ☐ Carrier Status
- ☐ Predictive Testing
- ☐ Prenatal Diagnosis (maternal blood required)
  Contact Lab prior to ordering

III. Clinical Information and Family History

Testing will NOT be initiated without this information.
Please provide pedigree and ethnicity

Other family members tested previously:
☐ No
☐ Yes Name:_____

Relationship to Patient: _____