

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 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: <small>(as per Manitoba Health Card)</small>																																																																							
*Ordering Facility:	Inpatient Location:	*Date of Birth: <small>(dd/mm/yyyy)</small>	Address:																																																																						
Address:		*Biological Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male																																																																							
*Critical Results Phone No:	*Fax No.:	*PHIN:																																																																							
ADDITIONAL COPY OF REPORT (FOR MANITOBA PHYSICIANS ONLY)																																																																									
*Last & Full First Name:	Billing Code:	*Alternate ID: <small>(include ID type with number i.e. RCMP, SK, DND, etc.)</small>	*Phone No:																																																																						
*Facility Name:		MHSC#:	MRN:																																																																						
Address:		Encounter Number:																																																																							
Phone No:	*Fax No.:	Demographics verified with: <input type="checkbox"/> Health Card <input type="checkbox"/> eChart/CR <input type="checkbox"/> Armband																																																																							
CONTACT INFO		COLLECTION INFORMATION																																																																							
Clinic/Laboratory Contact Name:	*Collector:	*Collection Time: <small>(hh:mm)</small>																																																																							
Clinic/Laboratory Contact Telephone No.:	*Collection Date: <small>(dd/mm/yyyy)</small>	*Collection Facility/Lab:																																																																							
I. Test Requested See website for test details, guidelines and sample requirements https://apps.sbgq.mb.ca/labmanual/		II. Reason for Test May require prior genetic consultation before testing.																																																																							
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