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 Test Requistion

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: 204-787-3846
SHIP SAMPLES AT ROOM TEMPERATURE

Additional requisitions and sample requirements at:
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: Encounter #:
Ph #:	Fax #:	Patient Ph #: Patient Address:
Facility Name/ Address:		Demographics verified via: ☐ Health Card ☐ Armband ☐ eChart/CR ☐ Other
Collection Contact Information (Clinic/Laboratory Contact):		

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

- ☐ Angelman Syndrome MD
- ☐ APOE MD
- ☐ Ashkenazi Jewish Panel (ASPA, HEXA, ELP1, FANCC) MD
- ☐ Charcot-Marie-Tooth type 1A MD
- ☐ Cystic Fibrosis/ CFTR-related disorders MD
  Ethnic background required: _____
- ☐ DNA banking MD
- ☐ Fragile X/ FMR1- related disorders MD
- ☐ Hemochromatosis (transferrin saturation required) MD
- ☐ Hereditary Neuropathy with Liability to Pressure Palsies MD
- ☐ Huntington disease MD
- ☐ Kennedy disease MD
- ☐ Manitoba Targeted Founder Variants MD
  (Variant List: https://apps.sbgh.mb.ca/labmanual/)
  - ☐ Hutterite Carrier Panel (Genetics only) MD
  - ☐ HNF1α (First Nations Variant) MD
  - ☐ Hypertrophic Cardiomyopathy (Mennonite Variant) MD
  - ☐ Hypophosphatasia (Mennonite Variants) MD
  - ☐ Limb-Gridle Muscular Dystrophy 2H&2I (Hutterite variants) MD
  - ☐ Pediatric Dx Panel (Genetics only) MD
    Ethnic background required: _____
  - ☐ Other Founder Variant(s) (provide gene and variant name): MD
    _____
- ☐ Myotonic Dystrophy Type 1 MD
- ☐ Non-Syndromic Deafness (GJB2 and GJB6) MD
- ☐ Oculopharyngeal Muscular Dystrophy MD
- ☐ Prader-Willi Syndrome MD
- ☐ Spinocerebellar ataxia types 1,2,3,6,7,8 MD
- ☐ Yq Microdeletion MD
- ☐ Other: _____ MD

* All **referred out** Genetic testing use "Out of center Genetic Testing Requisition- R250-10-103"

Sample Request

Samples must be labeled with patient name and PHIN or equivalent

Has this patient had a bone marrow transplant? ☐ Yes ☐ No

- ☐ Blood 2x4mL EDTA
- ☐ Blood 0.5-2mL EDTA (infant only)
- ☐ DNA 15 µg
  Minimum concentration 150ng/µL
- ☐ Other Sample Types (contact lab prior to ordering.)
  Sample volume may vary:
  - ☐ Cultured Amniocytes
  - ☐ Amniotic Fluid 4-10 mL
  - ☐ Tissue
    Pathology Reference No.
    _____
  - ☐ Other: _____

Delphic Barcode Label

Reason for Test

May require prior genetic consultation before testing

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

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

Clinical Information & Family History

Testing will **NOT** be initiated without this information. Please forward relevant documentation. Please provide pedigree.

☐ STAT testing

Reason: _____

Ethnic background: _____

Family Members previously tested:

- ☐ Yes, Name: _____
  DOB: _____
  Relationship: _____
- ☐ No

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