

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.

IMMUNOLOGY LABORATORY REQUISITION

[Autoimmune Testing available on R250-10-85]

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			*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:	Ph #:	Fax #:	Encounter #:		
Facility Name/ Address:			Patient Ph #:		
Last & Full First Name:			Patient Address:		
Ph #:			Demographics verified via:		
Fax #:			<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other		
Facility Name/ Address:					

Collection Information (fields marked with * required by person collecting sample)		
* Collector:	* Collection Date:	* Collected via: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line
* Collection Facility/Lab:	* Collection Time:	Referring Lab: # of tubes sent _____ Samples shipped frozen <input type="checkbox"/>
# Serum vial(s) _____	# Plasma vials(p) _____	

Clinical Information/Diagnosis: Monoclonal Antibody Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes Generic Name: _____ Family History of Alpha-1-Antitrypsin Deficiency: <input type="checkbox"/> No <input type="checkbox"/> Yes 24 Hour Urine Collection: Start Date/Time: _____ Stop Date/Time: _____ Vol(ml): _____	LAB USE ONLY PLACE BARCODE HERE
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Nephelometry/Turbidimetry	
<input type="checkbox"/> IGG Immunoglobulin IgG <input type="checkbox"/> IGA Immunoglobulin IgA <input type="checkbox"/> IGM Immunoglobulin IgM <input type="checkbox"/> AATD Alpha-1-Antitrypsin <input type="checkbox"/> CEI C1 Esterase Inhibitor <input type="checkbox"/> A2M Alpha-2-Macroglobulin	<input type="checkbox"/> C3 Complement C3 <input type="checkbox"/> C4 Complement C4 <input type="checkbox"/> RF Rheumatoid Factor <input type="checkbox"/> IGGS IgG Subclasses <input type="checkbox"/> FLCH Serum Free Light Chains
<input type="checkbox"/> CH50 Total Complement Activity	Separate serum within one (1) hour of collection. Immediately freeze and store aliquot at -70°C. If sample cannot be frozen at -70°C and shipped on dry ice, freeze at -20°C and ship frozen.

Electrophoresis	
<input type="checkbox"/> PE Serum Monoclonal Protein Investigation	Includes IgG, IgA, IgM & FLCH
<input type="checkbox"/> PEU 24 Hour Urine Monoclonal Protein Investigation	Random/Spot urine samples will be rejected
<input type="checkbox"/> AATP Alpha-1-Antitrypsin Phenotyping	Automatic reflex for patients with AATD <1.1g/L

Other	
<input type="checkbox"/> VIS Serum Viscosity	Minimum 20ml RED TOP, NO GEL clotted at 37°C
<input type="checkbox"/> CRYO Cryoglobulin	Minimum 15ml RED TOP, NO GEL clotted at 37°C
<input type="checkbox"/> IGD Immunoglobulin IgD	Pediatric patients or patients with IgD Monoclonal Protein

Referral	
<input type="checkbox"/> MIS8 Referral tests to all labs excluding MITOGEN	See LIM entry for each test. Prior approval may be required. Complete the Immunology/Hematology Approval for Testing Form [F150-100-100]
<input type="checkbox"/> MITO Referral tests to MITOGEN Diagnostics	

List tests: