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		
*Last & Full First Name:		Billing Code:
Inpatient Location:	Critical Results Ph #:	
*Facility Name/ Address		
Ph #:	Fax #:	
Copy Report To *(if info missing, report may not be sent)*:		
Last & Full First Name:	Ph #:	Fax #:
Facility Name/ Address:		
Last & Full First Name:	Ph #:	Fax #:
Facility Name/ Address:		

Patient Information *(print or use addressograph)*
*Last/First Name: (per Health Card)

* Date of Birth (dd/mm/yyyy)
*Sex: □ Female □ Male

*PHIN: Specify Province or DND if different
MRN:
Encounter #:
Patient Ph #:

Patient Address:

Demographics verified via:
❑ Health Card ❑ Armband ❑eChart/CR ❑Other

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

Clinical Information/Diagnosis:

Monoclonal Antibody Therapy: □ No □ Yes Generic Name: _____

Family History of Alpha-1-Antitrypsin Deficiency: □ No □ Yes

24 Hour Urine Collection: Start Date/Time: _____ Stop Date/Time:_____ Vol(ml):_____

LAB USE ONLY
PLACE BARCODE HERE

Nephelometry/Turbidimetry			
☐ **IGG**	Immunoglobulin IgG	☐ **C3**	Complement C3
☐ **IGA**	Immunoglobulin IgA	☐ **C4**	Complement C4
☐ **IGM**	Immunoglobulin IgM	☐ **RF**	Rheumatoid Factor
☐ **AATD**	Alpha-1-Antitrypsin	☐ **IGGS**	IgG Subclasses
☐ **CEI**	C1 Esterase Inhibitor	☐ **FLCH**	Serum Free Light Chains
☐ **A2M**	Alpha-2-Macroglobulin		
☐ **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			
☐ **PE**	Serum Monoclonal Protein Investigation	**Includes IgG, IgA, IgM & FLCH**	
☐ **PEU**	24 Hour Urine Monoclonal Protein Investigation	**Random/Spot urine samples will be rejected**	
☐ **AATP**	Alpha-1-Antitrypsin Phenotyping	**Automatic reflex for patients with AATD <1.1g/L**	
Other			
☐ **VIS**	Serum Viscosity	**Minimum 20ml RED TOP, NO GEL clotted at 37°C**	
☐ **CRYO**	Cryoglobulin	**Minimum 15ml RED TOP, NO GEL clotted at 37°C**	
☐ **IGD**	Immunoglobulin IgD	**Pediatric patients or patients with IgD Monoclonal Protein**	
Referral			
☐ **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]**	
☐ **MITO**	Referral tests to MITOGEN Diagnostics		

List tests:

Shared health Soins communs Manitoba

Immunology Laboratory, Health Sciences Centre
MS543L, 820 Sherbrook St
Winnipeg, MB R3A 1R9
Phone: 204-787-2156
Fax: 204-787-2058

Additional requisitions and sample requirements available at:
https://apps.sbgh.mb.ca/labmanual/

R250-10-21 V02
Approval Date: 09-OCT-2020