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.

TRANSPLANT IMMUNOLOGY LABORATORY REQUISITION

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: □ Female □ 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: Ph #: Fax #:		Patient Address:
Facility Name/ 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 ❑

SPECIAL REQUESTS/ ADDITIONAL INFORMATION

RECIPIENT HISTORY
(Required for initial appointment, cPRA, HLA Crossmatch)

# of pregnancies: _____
# of transfusions: _____ Date(s): _____
Previous transplants: _____ Date(s): _____

Verified by Lab: ____

DRUG THERAPY
(**MUST** *be completed for all antibody and crossmatch requests due to test interference*)

❑ Thymoglobulin ❑ IVIG ❑ Rituximab
❑ Other _____

Date(s) of therapy: _____

RECIPIENT

Type of Transplant:
❑ Kidney ❑ Lung ❑ Heart ❑ Pancreas ❑ K/P
❑ Other _____

❑ **HLA Typing** ❑ Hold ❑ Run

❑ **HLA Antibody Screening**
- ❑ Waiting List
- ❑ Post Transfusion *(to be drawn 14 -18 days post transfusion)*
  Transfusion Date: _____
- ❑ Post Transplant: _____
- ❑ Biopsy
- ❑ cPRA
- ❑ Store only

❑ **HLA Crossmatch**
- ❑ Preliminary
- ❑ Final

CTR #: _____ *(required for KPD Crossmatches only)*

❑ **Referral**
- ❑ Instructions: _____

LIVING DONOR

Relationship to Recipient:
_____
if Partner - pregnancies with recipient ❑ Yes ❑ No
❑ KPD CTD #: _____
❑ NDAD CTD #: _____

Recipient Name: _____
Recipient PHIN: _____

Or for KPD/NDAD

Recipient CTR#: _____

❑ **HLA Typing** ❑ Hold ❑ Run

❑ **HLA Crossmatch**
- ❑ Virtual
- ❑ Preliminary
- ❑ Final

DECEASED DONOR

ID #: _____

CTD #: _____

Specimen Source:
- ❑ Blood
- ❑ Spleen

❑ **HLA Typing**

❑ **HLA Crossmatch**

OTHER DONOR

ID #: _____ CTD #: _____

❑ **HLA Typing** ❑ **HLA Crossmatch**

LABORATORY USE ONLY

Accession Number:	Accessioned By:	Historical Chart: ❑ Yes ❑ No

Comments:

Shared health Soins communs Manitoba
SAP # 358018

Transplant Immunology Laboratory
Room 351, 777 William Avenue
Winnipeg, MB R3E 3R4
Phone: 204-789-1143
Fax: 204-789-1198

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

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