

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 <i>(print or use addressograph)</i>	
*Last & Full First Name: _____		*Last/First Name: (per Health Card) _____	
Billing Code: _____		* Date of Birth (dd/mm/yyyy) _____	
Inpatient Location: _____	Critical Results Ph #: _____	*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
*Facility Name/ Address _____			
Ph #: _____	Fax #: _____	*PHIN: Specify Province or DND if different _____	
Copy Report To <i>(if info missing, report may not be sent):</i>			
Last & Full First Name: _____	Ph #: _____	Fax #: _____	
Facility Name/ Address: _____			
Last & Full First Name: _____	Ph #: _____	Fax #: _____	
Facility Name/ Address: _____			
Demographics verified via: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other			
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) _____		
SPECIAL REQUESTS/ ADDITIONAL INFORMATION			
RECIPIENT HISTORY <i>(Required for initial appointment, cPRA, HLA Crossmatch)</i>		DRUG THERAPY <i>(MUST be completed for all antibody and crossmatch requests due to test interference)</i>	
# of pregnancies: _____ # of transfusions: _____ Date(s): _____ Previous transplants: _____ Date(s): _____ Verified by Lab: _____		<input type="checkbox"/> Thymoglobulin <input type="checkbox"/> IVIG <input type="checkbox"/> Rituximab <input type="checkbox"/> Other _____ Date(s) of therapy: _____	
RECIPIENT	LIVING DONOR	DECEASED DONOR	
Type of Transplant: <input type="checkbox"/> Kidney <input type="checkbox"/> Lung <input type="checkbox"/> Heart <input type="checkbox"/> Pancreas <input type="checkbox"/> K/P <input type="checkbox"/> Other _____ <input type="checkbox"/> HLA Typing <input type="checkbox"/> Hold <input type="checkbox"/> Run <input type="checkbox"/> HLA Antibody Screening <input type="checkbox"/> Waiting List <input type="checkbox"/> Post Transfusion <i>(to be drawn 14 -18 days post transfusion)</i> Transfusion Date: _____ <input type="checkbox"/> Post Transplant: _____ <input type="checkbox"/> Biopsy <input type="checkbox"/> cPRA <input type="checkbox"/> Store only <input type="checkbox"/> HLA Crossmatch <input type="checkbox"/> Preliminary <input type="checkbox"/> Final CTR #: _____ <i>(required for KPD Crossmatches only)</i> <input type="checkbox"/> Referral <input type="checkbox"/> Instructions: _____	Relationship to Recipient: _____ if Partner - pregnancies with recipient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> KPD CTD #: _____ <input type="checkbox"/> NDAD CTD #: _____ Recipient Name: _____ Recipient PHIN: _____ <i>Or for KPD/NDAD</i> Recipient CTR#: _____ <input type="checkbox"/> HLA Typing <input type="checkbox"/> Hold <input type="checkbox"/> Run <input type="checkbox"/> HLA Crossmatch <input type="checkbox"/> Virtual <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	ID #: _____ CTD #: _____ Specimen Source: <input type="checkbox"/> Blood <input type="checkbox"/> Spleen <input type="checkbox"/> HLA Typing <input type="checkbox"/> HLA Crossmatch	
		OTHER DONOR	
		ID #: _____ CTD #: _____ <input type="checkbox"/> HLA Typing <input type="checkbox"/> HLA Crossmatch	
LABORATORY USE ONLY			
Accession Number: _____	Accessioned By: _____	Historical Chart: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments: _____			