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.

Urine Drug Screen Requisition

Lab Use Only

Place Barcode Label Here

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)*

Random Sample			
♦ Collected by:	♦ Collection Date:	♦ Time:	♦ Collection Facility/Lab:

Number of tubes/containers sent: Tubes _____ Containers _____ Check if samples shipped frozen ❑

Results are only to be used for patient healthcare. Testing is not to be ordered or used, for legal, custody, employment or occupational health reasons.

Drug testing monitors recent drug consumption (days to weeks). Detection window for drugs is dependent on drug and dose.

ONLY immunoassay testing will be performed if both comprehensive and urine drug screens are ordered, unless reason for ordering both is provided below.

Reason: _____

_____

Immunoassay Urine Drug Screens (Performed at Westman Laboratory and St. Boniface Laboratory, daily)

☐ Cannabinoids	CAN	☐ Benzodiazepines	BEN
☐ Cocaine	COCM	☐ Oxycodone	OXYC
☐ Opiates	OPI	☐ Amphetamines	AMP
☐ Methadone	MDO		

(*This is the preferred test for monitoring methadone use*)

Lab Information: Register TDXS (if sending to SBH) or DAUW (if sending to WL) + each individual drug. If all are checked order STRE.

☐ **Comprehensive Drug Screen** DRUG

(Performed at St. Boniface Laboratory – results will be available within 10 days)

See Lab Information Manual for list of detected drugs (https://apps.sbgh.mb.ca/labmanual/test/view?seedId=39929). Excludes salicylate, NSAIDs, diuretics, antibiotics, steroids and pesticides.

***Reason for Drug Screen** (accepted for medical purposes only)

☐ Opiate Replacement Therapy ☐ Transplant Patient

☐ Other (provide reason for order):_____

***List ALL known medications and recreational drugs used in the last 2 weeks**:

Medications/Drugs: _____

_____

For Comprehensive Drug Screens **copy of requisition form must** accompany samples to:
Biochemistry, St Boniface Hospital, 409 Tache Avenue, Winnipeg, MB R2H 2A6 Phone: (204) 237-2475.