

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 Form

Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection.

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION	
*Last & Full First Name:	Billing Code:	*Last/First Name: (per MB. Health Card)	
*Ordering Facility:		* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Critical Results Phone Number:	Fax No:	*PHIN:	
Physician Signature:	Phone No.:	*Specify Province or DND if different	
COPY REPORT TO: (if info missing, report may not be sent)		MRN:	
Last & Full Name:	Fax No:	Encounter Number:	
Facility Name/ Address:	Phone No.:	Patient Phone No:	
Last & Full Name:	Fax No:	Patient Address:	
Facility Name/ Address:	Phone No.:	Demographics verified with: <input type="checkbox"/> Prov. Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR	
Fields marked with "♦" required by person collecting sample		♦Collection Date: ♦Time:	
Referring Lab: # of tubes sent _____			
Reason for Drug Screen: In addition to medical reason, provide a list of the drug classes or specific drugs being investigated:			
List <u>ALL</u> current medications and recreational drug use:			
Immunoassay Drug Screens			
Selective Testing (Urine)			Lab Information
<input type="checkbox"/> Cannabis	CAN	<input type="checkbox"/> Benzodiazepines	BEN
<input type="checkbox"/> Cocaine	COCM	<input type="checkbox"/> Oxycodone	OXYC
<input type="checkbox"/> Opiates	OPI	<input type="checkbox"/> Methadone	MDO
<input type="checkbox"/> Amphetamines	AMP		
<input type="checkbox"/> Comprehensive Drug Screen (Urine)			DRUG
<ul style="list-style-type: none"> Chromatographic of therapeutic and abused drugs. Excludes salicylate, NSAIDs, diuretics, antibiotics, steroids and pesticides. See list of detected drugs in the Shared Health Lab Information Manual at www.dsmanitoba.ca Click: Info for Professionals, then LIM. In the 'search' box, type: drug Click: DRUG SCREEN – (U), then Drug Screen Listing 			
<input type="checkbox"/> Date Rape Drug Screen (Urine - must be collected within 8 hours of patient awakening)			DRDS
<ul style="list-style-type: none"> Includes: benzodiazepine (immunoassay), gammahydroxybutyrate and comprehensive screen 			
For Comprehensive and Date Rape 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			