DIAGNOSTIC SERVICES MANITOBA

SERVICES DIAGNOSTIC MANITOBA

Test Add-On Form – SBH

LOCATION:

WARD
PATIENT NAME: *
LAST, FIRST

DATE OF BIRTH:
DD/MMM/YYYY

SEX F☐ M☐

MB PHIN: *
(Specify province if different)
PHYSICIAN: (PRINT)
LAST, FIRST
ORDERING PROFESSIONAL: *
(If different from physician)

Accession Number (if available): _____ (found on lab results printout)

Collection Date: _____ **Time:** _____

BIOCHEMISTRY
FAX 204-231-2245

	TEST	CODE		TEST	CODE
	Na, K, Cl	K		T. Bili	TB
	CO2	CO2		D. Bili	DB
	Glucose	G		AST	AST
	Urea	U		ALT	ALT
	Creatinine	CR		LD	LD
	Total Protein	TP		CK	CK
	Albumin	AL		Alk. Phos	ALK
	Calcium	CA		GGT	GGT
	Phosphorus	P		Lipase	LIP
	Magnesium	MG		Digoxin*	DIG
	Chol,Trig,HDL	LIPP		TSH	TSH
	β-Hydroxy	BHB		Troponin	HTNT
				Other Tests*	

***If drug level is being ordered; please complete Therapeutic Drug Dosage Information below:**

Therapeutic Drug Dosage Information			
Last Dose		Time:	Date:
Next Dose		Time:	Date:
Finish		Time:	Date:

HEMATOLOGY
FAX 204-237-2494

	TEST	CODE
	Sedimentation Rate	ESR
	Reticulocyte Count	RETA
	PT/INR/Pfib	PT
	APTT **MUST** be **<4hrs** old	APTT
	Fibrinogen **MUST** be **<4hrs**	CFIB
	D-Dimer **MUST** be **<4hrs**	DDIM
	Malaria	MAL
	Other Tests	

IMMUNOLOGY
FAX 204-233-0826

	TEST	CODE
	Anti-Nuclear Antibody	ANA
	Anti-Neutrophilic Cytoplasmic Antibodies	ANCA
	Tissue Transglut-IgG	TGG
	Other	

Order requested by:

Name:_____

Phone Number: _____Time:_____

Lab use on only:

Order processed by:

Name: _____Time:_____