

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.



LOCATION:

WARD PATIENT NAME: * LAST, FIRST

DATE OF BIRTH: DD/MM/YYYY

SEX F M

MB PHIN: * (Specify province if different) PHYSICIAN: (PRINT) LAST, FIRST

ORDERING PROFESSIONAL: * (If different from physician)

Test Add-On Form – SBH

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			
		Time:	Date:
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: _____