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.

Hôpital St-Boniface Hospital

DIAGNOSTIC SERVICES
OF MANITOBA
SERVICES DE DIAGNOSTIC
DU MANITOBA

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)

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			
Last Dose		Time:	Date:
Next Dose		Time:	Date:
Finish		Time:	Date:

Order requested by:

Name:_____

Phone Number: _____Time:_____

Lab use on only:

Order processed by:

Name: _____Time:_____

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	