

# IMMUNOLOGY LABORATORY REQUISITION

[Autoimmune Testing available on R250-10-85]

Fields marked with \* are mandatory and must be clearly legible or can result in specimen rejection

<b>Ordering Provider Information</b>			<b>Patient Information</b> <i>(print or use addressograph)</i>		
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)		
Inpatient Location:	Critical Results Ph #:		* Date of Birth (dd/mm/yyyy)		
*Facility Name/ Address			*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Ph #:	Fax #:		*PHIN: Specify Province or DND if different		
<b>Copy Report To</b> <i>(if info missing, report may not be sent):</i>			MRN:		
Last & Full First Name:	Ph #:	Fax #:	Encounter #:		
Facility Name/ Address:			Patient Ph #:		
Last & Full First Name:	Ph #:	Fax #:	Patient Address:		
Facility Name/ Address:			Demographics verified via:		
			<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other		

<b>Collection Information (fields marked with * required by person collecting sample)</b>					
* Collector:		* Collection Date:		* Collected via: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line	
* Collection Facility/Lab:		* Collection Time:		Referring Lab: # of tubes sent _____	
# Serum vial(s) _____		# Plasma vials(p) _____		Samples shipped frozen <input type="checkbox"/>	

<b>Clinical Information/Diagnosis:</b>  <b>Monoclonal Antibody Therapy:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Generic Name:</b> _____  <b>Family History of Alpha-1-Antitrypsin Deficiency:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>24 Hour Urine Collection:</b> Start Date/Time: _____ Stop Date/Time: _____ Vol(ml): _____	<b>LAB USE ONLY</b> <b>PLACE BARCODE HERE</b>
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<b>Nephelometry/Turbidimetry</b>	
<input type="checkbox"/> <b>IGG</b> Immunoglobulin IgG <input type="checkbox"/> <b>IGA</b> Immunoglobulin IgA <input type="checkbox"/> <b>IGM</b> Immunoglobulin IgM <input type="checkbox"/> <b>AATD</b> Alpha-1-Antitrypsin <input type="checkbox"/> <b>CEI</b> C1 Esterase Inhibitor <input type="checkbox"/> <b>A2M</b> Alpha-2-Macroglobulin	<input type="checkbox"/> <b>C3</b> Complement C3 <input type="checkbox"/> <b>C4</b> Complement C4 <input type="checkbox"/> <b>RF</b> Rheumatoid Factor <input type="checkbox"/> <b>IGGS</b> IgG Subclasses <input type="checkbox"/> <b>FLCH</b> Serum Free Light Chains
<input type="checkbox"/> <b>CH50</b> Total Complement Activity	Separate serum within one (1) hour of collection. Immediately freeze and store aliquot at -70°C. If sample cannot be frozen at -70°C and shipped on dry ice, freeze at -20°C and ship frozen.

<b>Electrophoresis</b>	
<input type="checkbox"/> <b>PE</b> Serum Monoclonal Protein Investigation	Includes IgG, IgA, IgM & FLCH
<input type="checkbox"/> <b>PEU</b> 24 Hour Urine Monoclonal Protein Investigation	Random/Spot urine samples will be rejected
<input type="checkbox"/> <b>AATP</b> Alpha-1-Antitrypsin Phenotyping	Automatic reflex for patients with AATD <1.1g/L

<b>Other</b>	
<input type="checkbox"/> <b>VIS</b> Serum Viscosity	Minimum 20ml RED TOP, NO GEL clotted at 37°C
<input type="checkbox"/> <b>CRYO</b> Cryoglobulin	Minimum 15ml RED TOP, NO GEL clotted at 37°C
<input type="checkbox"/> <b>IGD</b> Immunoglobulin IgD	Pediatric patients or patients with IgD Monoclonal Protein

<b>Referral</b>	
<input type="checkbox"/> <b>MIS8</b> Referral tests to all labs excluding MITOGEN	See LIM entry for each test. Prior approval may be required. Complete the Immunology/Hematology Approval for Testing Form [F150-100-100]
<input type="checkbox"/> <b>MITO</b> Referral tests to MITOGEN Diagnostics	

List tests:



**Immunology Laboratory, Health Sciences Centre**  
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 Fax: 204-787-2058

Additional requisitions and sample requirements available at:  
<https://apps.sbgf.mb.ca/labmanual/>

R250-10-21 V02  
 Approval Date: 09-OCT-2020