

# The New Cadham Provincial Laboratory Requisition

May 2010





**Cadham Provincial Laboratory  
General Requisition**



SEE BACK FOR REQUISITION INSTRUCTIONS  
ONLY ONE SPECIMEN TYPE PER REQUISITION

All areas of the requisition must be completed (please print clearly)

Cadham Provincial Laboratory Tel: (204) 945-6123  
P.O. Box 8450 Fax: (204) 786-4770  
750 William Avenue Email: cadham@gov.mb.ca  
Winnipeg, MB R3C 3Y1 Website: www.gov.mb.ca/health/publichealth/cpl

ADDRESSOGRAPH

In with the New

<b>RELEVANT CLINICAL INFORMATION</b>		<b>PATIENT INFORMATION</b>	
Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured		PHIN: _____ MB Health Reg. # _____	
Travel/Treatment History: <input type="checkbox"/> Autopsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Borne Illness <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Dialysis <input type="checkbox"/> Pregnant		Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Provinces/Territories <input type="checkbox"/> Military # <input type="checkbox"/> Other _____	
Signs and Symptoms: <input type="checkbox"/> Bronchitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice		Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U <input type="checkbox"/> A Chart/Clinic/Lab # _____ YYYYMMDD	
Reason for Test: <input type="checkbox"/> Immigration <input type="checkbox"/> Occupational <input type="checkbox"/> Other: <input type="checkbox"/> Needlestick <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Mucosal		Patient Legal Name: Last _____ First Name _____	
<b>SPECIMEN INFORMATION</b>		Street or Other (e.g., General Delivery) _____ Phone # _____	
Specimen Type: _____ Specimen Source: _____		City/Municipality/First Nations Reserve _____ Postal Code _____	
Collected At: _____ Date/Time: _____ YYYYMMDD H:MM		<b>RETURN REPORT TO:</b> Ordering Practitioner Last Name _____ First _____ Initial(s) _____	
<b>COPY REPORT TO:</b>		Facility _____	
Ordering Practitioner Last Name _____ First Name _____		Facility Address _____ City/Town _____	
Facility _____ Secure Fax # _____		Postal Code _____ Phone # _____ Secure Fax # _____	

<b>SEROLOGY</b>		<b>PARASITOLOGY</b>	
SeroLOGY Test Panels (1) <input type="checkbox"/> Blood Borne Pathogen <input type="checkbox"/> Prenatal Panel <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT (2) <input type="checkbox"/> Post Exposure: Exposed Panel (3) <input type="checkbox"/> Post Exposure: Source Panel (1, 2) <input type="checkbox"/> Other _____		<input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Pinworm Examination <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scrapings <input type="checkbox"/> Identification	
Retrovirus (4) <input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HTLV1/2Ab Syphilis <input type="checkbox"/> Screen <input type="checkbox"/> DFA		<b>MICROBIOLOGY/BACTERIOLOGY</b> <input type="checkbox"/> C&S <input type="checkbox"/> Chlamydia and Gonorrhea (NAAT) <input type="checkbox"/> MRSA Screen <input type="checkbox"/> Chlamydia DFA (Microtrak) <input type="checkbox"/> VRE Screen <input type="checkbox"/> Fungus Culture <input type="checkbox"/> Clostridium difficile Toxin <input type="checkbox"/> GBS Prenatal Screen <input type="checkbox"/> Verotoxin Testing <input type="checkbox"/> Spore/Sterilizer Testing Referral Isolate: <input type="checkbox"/> Identification <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Subtyping Isolate Information: _____	
Hepatitis <input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> HBV PCR/Quant <input type="checkbox"/> WNV <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBeAb (Immunity) <input type="checkbox"/> HCV PCR/Qual <input type="checkbox"/> HBcAb (IgM) <input type="checkbox"/> HBeAg <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> HBcAb (Total) <input type="checkbox"/> HCV Ab <input type="checkbox"/> HCV Genotyping		<b>VIROUS DETECTION</b> <input type="checkbox"/> Viral Studies <input type="checkbox"/> CMV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)	
<b>Miscellaneous Serology</b> CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Parvo B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG WNV <input type="checkbox"/> IgM		<b>OTHER TESTS OR REQUESTS</b>	
<input type="checkbox"/> Lyme Ab <input type="checkbox"/> Mycoplasma pneumoniae IgM			

Name _____ PHIN _____	CPL	Name _____ PHIN _____	CPL
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Specimen label stickers. Please fill one in and affix to the accompanying specimen container.

MG-696 (Rev. 05/05)


# What's New?

- Larger size, different format
- Tick box menu (not all-inclusive)
- Panel requests
- No requisition number
- COPY TO: field
- Room for Addressograph
- Instructions on the back
- Outbreak Code box

# General Things

- No requisition number
  - Accession number will be assigned at CPL
  - Inquiries about misplaced or outstanding reports require only PHIN or name
  - Some tracking activities will need to be adjusted
- Larger 8 ½ X 11 inch size – fits most filing systems better
- No carbon copies attached – to cut down on paper use (being scanned and electronically stored at CPL)

# From the Top

**Cadham Provincial Laboratory**  **General Requisition**

SEE BACK FOR REQUISITION INSTRUCTIONS  
ONLY ONE SPECIMEN TYPE PER REQUISITION

All areas of the requisition must be completed (please print clearly)

Cadham Provincial Laboratory  
P.O. Box 8450  
750 William Avenue  
Winnipeg, MB R2C 3Y1

Tel: (204) 945-6123  
Fax: (204) 786-4770  
Email: cadham@gov.mb.ca  
Website: www.gov.mb.ca/health/public/eh/lpl

ADDRESS ONLY

<b>RELEVANT CLINICAL INFORMATION</b>		<b>PATIENT INFORMATION</b>	
Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured		Patient Name: _____ MB Health Reg. # _____	
Travel/Treatment History:		Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Provinces/Territories <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Borne Illness <input type="checkbox"/> Dialysis <input type="checkbox"/> Pregnant	
Signs and Symptoms:		Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U <input type="checkbox"/> A Chart/Clinic/Lab # _____	
<input type="checkbox"/> Autopsy <input type="checkbox"/> Bronchitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice		Patient Legal Name: Last _____ First Name _____	
Reason for Test:		Street or Other (e.g., General Delivery) _____ Phone # _____	
<input type="checkbox"/> Immigration <input type="checkbox"/> Occupational <input type="checkbox"/> Other: _____ <input type="checkbox"/> Needlestick <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Mucosal		City/Municipality/First Nations Reserve _____ Postal Code _____	
<b>SPECIMEN INFORMATION</b>		<b>RETURN REPORT TO:</b>	
Specimen Type: _____ Specimen Source: _____		Ordering Practitioner Last Name _____ First _____ Initial(s) _____	
Collected At: _____ Date/Time: _____ YYYYMMDD HHMM		Facility _____	
<b>COPY REPORT TO:</b>		Facility Address _____ City/Town _____	
Ordering Practitioner Last Name _____ First Name _____		Postal Code _____ Phone # _____ Secure Fax # _____	
Facility _____ Secure Fax # _____			

<b>SEROLOGY</b>		<b>PARASITOLOGY</b>	
Seroology Test Panels (1)		<input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Pinworm Examination <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scrapings <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT (2) <input type="checkbox"/> Post Exposure: Exposed Panel (3) <input type="checkbox"/> Post Exposure: Source Panel (1, 2) <input type="checkbox"/> Other _____	
Retrovirus (4)		<b>MICROBIOLOGY/BACTERIOLOGY</b>	
<input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HTLV1/2Ab <input type="checkbox"/> Syphilis <input type="checkbox"/> Screen <input type="checkbox"/> DFA		<input type="checkbox"/> GAS <input type="checkbox"/> Chlamydia and Gonorrhea (NAAT) <input type="checkbox"/> MRSA Screen <input type="checkbox"/> Chlamydia DFA (Microtrak) <input type="checkbox"/> VRE Screen <input type="checkbox"/> Fungal Culture <input type="checkbox"/> Clostridium difficile Toxin <input type="checkbox"/> GBS Prenatal Screen <input type="checkbox"/> Verotoxin Testing <input type="checkbox"/> Spore/Sterilizer Testing	
Hepatitis		Referal isolate: <input type="checkbox"/> Identification <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Subtyping	
<input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> Nucleic Acid (Plasma Only)(5) <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBeAb (Immunity) <input type="checkbox"/> HBV PCR/Quant <input type="checkbox"/> WNV <input type="checkbox"/> HBcAb (IgM) <input type="checkbox"/> HBeAg <input type="checkbox"/> HCV PCR/Qual <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> HBcAb (Total) <input type="checkbox"/> HCV Ab <input type="checkbox"/> HCV Genotyping		<b>VIRUS DETECTION</b>	
<b>Miscellaneous Serology</b>		<input type="checkbox"/> Viral Studies <input type="checkbox"/> CMV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)	
CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Parvo B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG WNV <input type="checkbox"/> IgM		<b>OTHER TESTS OR REQUESTS</b>	
<input type="checkbox"/> Lyme Ab <input type="checkbox"/> Mycoplasma pneumoniae IgM			

Name \_\_\_\_\_ PHEN \_\_\_\_\_

Name \_\_\_\_\_ PHEN \_\_\_\_\_

Specimen label stickers. Please fill one in and affix to the accompanying specimen container.

MD-696 (Rev. 05/08)

- Now called the “General Requisition” for some clarity
- Cadham Lab address and contacts more completely provided

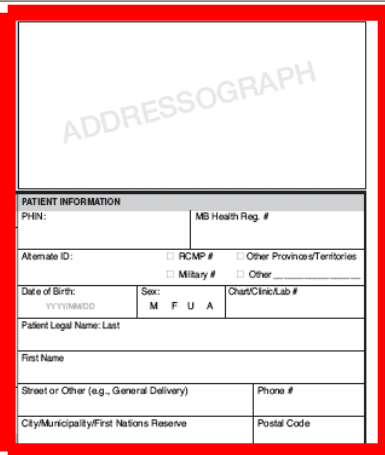
**Cadham Provincial Laboratory Manitoba Health**  
**General Requisition**

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 ONLY ONE SPECIMEN TYPE PER REQUISITION

All areas of the requisition must be completed (please print clearly)

Cadham Provincial Laboratory Tel: (204) 945-1233  
 P.O. Box 8460 Fax: (204) 786-4770  
 730 Wilkes Avenue Email: cadham@pcr.mb.ca  
 Winnipeg, MB R3C 3Y1 Website: www.gov.mb.ca/health/publichealth/pcr

<b>RELEVANT CLINICAL INFORMATION</b>		<b>PATIENT INFORMATION</b>	
Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured		PHIN: _____ MB Health Reg. # _____	
<b>Travel/Treatment History:</b>		Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Provinces/Territories	
<input type="checkbox"/> Autopsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Borne Illness <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Dialysis <input type="checkbox"/> Pregnant		<input type="checkbox"/> Military # <input type="checkbox"/> Other _____	
<b>Signs and Symptoms:</b>		Date of Birth: _____ Sex: _____ Chart/Clinic/Lab # _____ YYYYMMDD M F U A	
<input type="checkbox"/> Bronchovillitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice		Patient Legal Name: Last _____ First Name _____	
<b>Other:</b>		Street or Other (e.g., General Delivery) _____ Phone # _____	
<b>Reason for Test:</b>		City/Municipality/First Nations Reserve _____ Postal Code _____	
<input type="checkbox"/> Immigration <input type="checkbox"/> Occupational <input type="checkbox"/> Other: _____ <input type="checkbox"/> Needlestick <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Mucosal		Ordering Practitioner Last Name _____ First _____ Initial(s) _____	
<b>SPECIMEN INFORMATION</b>		Facility _____	
Specimen Type: _____	Specimen Source: _____	Facility Address _____ City/Town _____	
Collected At: _____	Date/Time: YYYYMMDD HHMM	Postal Code _____	Phone # _____
<b>COPY REPORT TO:</b>		Secure Fax # _____	
Ordering Practitioner Last Name _____ First Name _____	Facility _____		
Facility _____	Secure Fax # _____	Postal Code _____	Phone # _____
<b>SEROLOGY</b>		<b>PARASITOLOGY</b>	
<b>Serology Test Panels (1)</b>		<input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Pinworm Examination <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scrapings <input type="checkbox"/> Identification	
<input type="checkbox"/> Blood Borne Pathogen <input type="checkbox"/> Prenatal Panel <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT (2) <input type="checkbox"/> Post Exposure: Exposed Panel (3) <input type="checkbox"/> Post Exposure: Source Panel (1, 2) <input type="checkbox"/> Other _____	<input type="checkbox"/> Syphilis <input type="checkbox"/> Screen <input type="checkbox"/> DFA	<b>MICROBIOLOGY/BACTERIOLOGY</b>	
<b>Retrovirus (4)</b> <input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HTLV1/2Ab	<b>Hepatitis</b> <input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> HBeAb (Immunity) <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> WNV <input type="checkbox"/> HBeAb (IgM) <input type="checkbox"/> HBeAg <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> HBeAb (Total) <input type="checkbox"/> HCV Ab <input type="checkbox"/> HCV Genotyping	<input type="checkbox"/> GAS <input type="checkbox"/> Chlamydia and Gonorrhea (NAAT) <input type="checkbox"/> MRSA Screen <input type="checkbox"/> Chlamydia DFA (Microtrak) <input type="checkbox"/> VRE Screen <input type="checkbox"/> Fungus Culture <input type="checkbox"/> Clostridium difficile Toxin <input type="checkbox"/> GBS Prenatal Screen <input type="checkbox"/> Verotoxin Testing <input type="checkbox"/> Spore/Sterilizer Testing Referral Isolate: <input type="checkbox"/> Identification <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Subtyping Isolate Information: _____	
<b>Mitochondrial Serology</b> CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Papano B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> WNV <input type="checkbox"/> IgM	<input type="checkbox"/> Lyme Ab <input type="checkbox"/> Mycoplasma pneumoniae IgM	<b>VIRUS DETECTION</b> <input type="checkbox"/> Viral Studies <input type="checkbox"/> CMV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)	
<b>OTHER TESTS OR REQUESTS</b>			
Name _____ PHIN _____			



**ADDRESSOGRAPH**

<b>PATIENT INFORMATION</b>	
PHIN: _____	MB Health Reg. # _____
Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Provinces/Territories <input type="checkbox"/> Military # <input type="checkbox"/> Other _____	
Date of Birth: _____ YYYY/MM/DD	Sex: _____ M F U A
Chart/Clinic/Lab # _____	
Patient Legal Name: Last _____ First Name _____	
Street or Other (e.g., General Delivery) _____	Phone # _____
City/Municipality/First Nations Reserve _____	Postal Code _____
<b>RETURN REPORT TO:</b>	

## PATIENT INFORMATION:

Room for Addressograph, also some interesting new demographics required for public health, in addition to the usual stuff (name, DOB, address):



- PHIN: this is now the required health number and is preferred over MH number
- ALTERNATE ID: where no Mb PHIN is available, include a federal (RCMP or military #), other province PHIN, insurance company policy # and name of company
- SEX: M-F-T-A: More than M or F? Recognizes TTT (transsexual, transgender, two-spirited) orientations and ambiguous circumstances
- PHONE #: Critical for some public health F/U



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Cadham Provincial Laboratory Tel: (204) 945-6123  
P.O. Box 8450 Fax: (204) 786-4770  
750 Wilson Avenue Email: cadham@gov.mb.ca  
Winnipeg, MB R3C 3Y1 Website: www.gov.mb.ca/health/publichealth/lpl

ADDRESSOGRAPH

<b>RELEVANT CLINICAL INFORMATION</b>		<b>PATIENT INFORMATION</b>	
Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured		PHN: _____ MB Health Reg. # _____	
<b>Travel/Treatment History:</b>		Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Province/Territories	
<input type="checkbox"/> Autopsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Borne Illness <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Dialysis <input type="checkbox"/> Pregnant		<input type="checkbox"/> Military # <input type="checkbox"/> Other _____	
<b>Signs and Symptoms:</b>		Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U <input type="checkbox"/> A Chart/Clinic/Lab # _____	
<input type="checkbox"/> Bronchitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice		Patient Legal Name: Last _____ First Name _____	
Other: _____		Street or Other (e.g., General Delivery) _____ Phone # _____	
<b>Reason for Test:</b>		City/Municipality/First Nations Reserve _____ Postal Code _____	
<input type="checkbox"/> Immigration <input type="checkbox"/> Occupational <input type="checkbox"/> Other: <input type="checkbox"/> Needlestick <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Mucosal		<b>RETURN REPORT TO:</b>	
<b>SPECIMEN INFORMATION</b>		Ordering Practitioner Last Name _____ First _____ Initial(s) _____	
Specimen Type: _____ Specimen Source: _____		Facility _____	
Collected At: _____ Date/Time: _____		Facility Address _____ City/Town _____	
<b>COPY REPORT TO:</b>		Postal Code _____ Phone # _____ Secure Fax # _____	
Ordering Practitioner Last Name _____ First Name _____		Facility _____	
Facility _____ Secure Fax # _____		Postal Code _____ Phone # _____ Secure Fax # _____	

RETURN REPORT TO:		
Ordering Practitioner Last Name	First	Initial(s)
Facility		
Facility Address		City/Town
Postal Code	Phone #	Secure Fax #

- PRACTITIONER INFORMATION: More explicit detail required regarding the ordering practitioner and where the report must go to: emphasis on secure fax delivery

<b>SEROLOGY</b>		<b>PARASITOLOGY</b>	
Serology Test Panels (1)		<input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Pinworm Examination <input type="checkbox"/> Blood Borne Pathogen <input type="checkbox"/> Prenatal Panel <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scrapings <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT (2)	
<input type="checkbox"/> Post Exposure: Exposed Panel (3) <input type="checkbox"/> Post Exposure: Source Panel (4, 5) <input type="checkbox"/> Other _____		<input type="checkbox"/> Identification	
<b>Retrovirus (1)</b>		<b>MICROBIOLOGY/BACTERIOLOGY</b>	
<input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HTLV1/2Ab		<input type="checkbox"/> C&S <input type="checkbox"/> Chlamydia and Gonorrhea (NAAT) <input type="checkbox"/> MRSA Screen <input type="checkbox"/> Chlamydia DFA (Microtrak) <input type="checkbox"/> VRE Screen <input type="checkbox"/> Fungus Culture <input type="checkbox"/> Clostridium difficile Toxin <input type="checkbox"/> GBS Prenatal Screen <input type="checkbox"/> Verotoxin Testing <input type="checkbox"/> Spore/Sterilizer Testing Referral Isolate: <input type="checkbox"/> Identification <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Subtyping	
<input type="checkbox"/> Syphilis <input type="checkbox"/> Screen <input type="checkbox"/> DFA		Isolate Information: _____	
<b>Hepatitis</b>		<b>VIRUS DETECTION</b>	
<input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> HBV PCR/Quant <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBeAb (Immunity) <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> WNV <input type="checkbox"/> HBeAb (IgM) <input type="checkbox"/> HBeAg <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> HBeAb (Total) <input type="checkbox"/> HCV Ab <input type="checkbox"/> HCV Genotyping		<input type="checkbox"/> Viral Studies <input type="checkbox"/> CMV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)	
<b>Miscellaneous Serology</b>		<b>OTHER TESTS OR REQUESTS</b>	
<input type="checkbox"/> CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Parvo B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> WNV <input type="checkbox"/> IgM			
<input type="checkbox"/> Lyme Ab <input type="checkbox"/> Mycoplasma pneumoniae IgM			
Name _____ PHN _____	Name _____ PHN _____	Specimen label stickers. Please fill one in and affix to the accompanying specimen container. MG-096 (Rev. 05/00)	

**Cadham Provincial Laboratory Manitoba Health**  
**General Requisition**

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 ONLY ONE SPECIMEN TYPE PER REQUISITION

All areas of the requisition must be completed (please print clearly)

Cadham Provincial Laboratory P.O. Box 9450 750 William Avenue  
 Tel: (204) 945-6123 Fax: (204) 786-4770  
 Email: cadham@gov.mb.ca

**RELEVANT CLINICAL INFORMATION**  
 Outbreak Code:  In-Patient  Out-Patient  Uninsured  
 Travel/Treatment History:

**Signs and Symptoms:**  
 Cough  Sore Throat  Fever  Lymphadenopathy  
 Bronchitis  Gastrointestinal  Pneumonia  
 Conjunctivitis  Headache  Rash  
 Chest Pain  Influenza-Like Illness  Sore Throat  
 Diarrhea  Jaundice  
 Other: \_\_\_\_\_

**Reason for Test:**  
 Immigration  Occupational  Other:  
 Needles/IDU  Sexual Assault  Mucosal

**SPECIMEN INFORMATION**  
 Specimen Type: \_\_\_\_\_ Specimen Source: \_\_\_\_\_  
 Collected At: \_\_\_\_\_ Date/Time: YYYYMMDD HHMM

**COPY REPORT TO:**  
 Ordering Practitioner Last Name First Name  
 Facility \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone # \_\_\_\_\_

**SEROLOGY**  
 Serology Test Panels (1)  
 Blood Borne Pathogen  Prenatal Panel  
 STI Panel  Prenatal HIV OPT OUT #  
 Post Exposure: Exposed Panel (1)  
 Post Exposure: Source Panel (1, 2)  
 Other \_\_\_\_\_

Retrovirus (1)  
 HIV1/2Ab  HTLV1/2Ab Syphilis  Screen  DFA

Hepatitis (1)  
 HBV IgG (Immunity)  HBV PCR/Quant  WNV  
 HAV IgM  HBsAb (Immunity)  HCV PCR/Quant  
 HBeAb (IgM)  HBeAg  HCV PCR/Quant  
 HBeAb (Total)  HCV Ab  HCV Genotyping

**Miscellaneous Serology**  
 CMV  IgM  IgG Parvo B19  IgM  IgG  
 EBV  IgM  IgG Rubella  IgM  IgG  
 HSV  IgM  IgG Toxoplasma  IgM  IgG  
 Measles  IgM  IgG Varicella  IgM  IgG  
 Mumps  IgM  IgG WNV  IgM  
 Lyme Ab  Mycoplasma pneumoniae IgM

**PARASITOLOGY**  
 Ova & Parasites  Pinworm Examination  
 Blood Smears  Skin Scrapings  
 Identification

**MICROBIOLOGY/BACTERIOLOGY**  
 C&S  Chlamydia and Gonorrhea (NAAT)  
 MRSA Screen  Chlamydia DFA (Microtrak)  
 VRE Screen  Fungus Culture  
 Clostridium difficile Toxin  QBS Prenatal Screen  
 Verotoxin Testing  Spore/Sterilizer Testing  
 Referral isolate:  Identification  Susceptibility Testing  Subtyping  
 Isolate Information: \_\_\_\_\_

**VIRUS DETECTION**  
 Viral Studies  CMV PCR (NAAT)  HSV PCR (NAAT)

**OTHER TESTS OR REQUESTS**

Name \_\_\_\_\_ PIN \_\_\_\_\_  
 Name \_\_\_\_\_ PIN \_\_\_\_\_  
 Specimen label stickers. Please fill one in and affix to the accompanying specimen container.

MI-696 (Rev. 05/05)

ADDRESSOGRAPH

**RELEVANT CLINICAL INFORMATION**

Outbreak Code:  In-Patient  Out-Patient  Uninsured

Travel/Treatment History:

- Specific place for registered outbreak codes to be recorded
- Important detail for inpatient, outpatient and uninsured service testing

**Cadham Provincial Laboratory** **Manitoba Health**

**General Requisition**

SEE BACK FOR REQUISITION INSTRUCTIONS  
ONLY ONE SPECIMEN TYPE PER REQUISITION

All areas of the requisition must be completed (please print clearly)

Cadham Provincial Laboratory  
P.O. Box 8450  
750 Wilton Avenue  
Winnipeg, MB R3C 3Y1

Tel: (204) 945-6123  
Fax: (204) 786-4770  
Email: cadham@gov.mb.ca  
Website: www.gov.mb.ca/health/publichealth/vlpl

**ADDRESSOGRAPH**

<b>RELEVANT CLINICAL INFORMATION</b>		<b>PATIENT INFORMATION</b>	
Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured		PHN: _____ MB Health Reg. # _____	
Travel/Treatment History:		Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Provinces/Territories	
<input type="checkbox"/> Autopsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Borne Illness <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Dialysis <input type="checkbox"/> Pregnant		<input type="checkbox"/> Military # <input type="checkbox"/> Other _____	
<b>Signs and Symptoms:</b> <input type="checkbox"/> Bronchitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice		Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U <input type="checkbox"/> A Chart/Clinic/Lab # _____	
Other: _____		Patient Legal Name: Last _____	
Reason for Test: _____		First Name _____	
_____		Street or Other (e.g., General Delivery) _____ Phone # _____	
_____		City/Municipality/First Nations Reserve _____ Postal Code _____	
<b>SPECIMEN INFORMATION</b>		<b>ORDER REPORT TO:</b>	
Specimen Type: _____ Specimen Source: _____		Ordering Practitioner Last Name _____ First _____ Initial(s) _____	
Collected At: _____ Date/Time: _____ YYYY/MM/DD HH/MM		Facility _____	
<b>COPY REPORT TO:</b>		Facility Address _____ City/Town _____	
Facility _____ Secure Fax # _____		Postal Code _____ Phone # _____ Secure Fax # _____	
<b>SEROLOGY</b>		<b>PARASITOLOGY</b>	
Serology Test Panels (1) <input type="checkbox"/> Blood Borne Pathogen <input type="checkbox"/> Prenatal Panel <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT # <input type="checkbox"/> Post Exposure: Exposed Panel (1, 2) <input type="checkbox"/> Post Exposure: Source Panel (1, 2) <input type="checkbox"/> Other _____		<input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Pinworm Examination <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scrapings <input type="checkbox"/> Identification	
Retrovirus (1) <input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HTLV1/2Ab Syphilis <input type="checkbox"/> Screen <input type="checkbox"/> DFA		<b>MICROBIOLOGY/BACTERIOLOGY</b>	
Hepatitis <input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> Nucleic Acid (Plasma Only) (1) <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBsAb (Immunity) <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> WNV <input type="checkbox"/> HBcAb (IgM) <input type="checkbox"/> HBsAg <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> HBcAb (Total) <input type="checkbox"/> HCV Ab <input type="checkbox"/> HCV Genotyping		<input type="checkbox"/> CAS <input type="checkbox"/> Chlamydia and Gonorrhea (NAAT) <input type="checkbox"/> MRSA Screen <input type="checkbox"/> Chlamydia DFA (Microtrak) <input type="checkbox"/> VRE Screen <input type="checkbox"/> Fungus Culture <input type="checkbox"/> Clostridium difficile Toxin <input type="checkbox"/> GBS Prenatal Screen <input type="checkbox"/> Verotoxin Testing <input type="checkbox"/> Spore/Sterilizer Testing Referral isolate: <input type="checkbox"/> Identification <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Subtyping Isolate Information: _____	
<b>Miscellaneous Serology</b> CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Parvo B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> WNV <input type="checkbox"/> IgM		<b>VIRUS DETECTION</b>	
<input type="checkbox"/> Lyme Ab <input type="checkbox"/> Mycoplasma pneumoniae IgM		<input type="checkbox"/> Viral Studies <input type="checkbox"/> CMV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)	
Name _____ PHN _____		<b>OTHER TESTS OR REQUESTS</b>	
Name _____ PHN _____		_____	

Specimen label stickers. Please fill one in and affix to the accompanying specimen container.

MG-656 (Rev. 05/06)

SPECIMEN INFORMATION	
Specimen Type:	Specimen Source:
Collected At: _____	Date/Time: _____ YYYY/MM/DD HH/MM
COPY REPORT TO:	

- Differentiates specimen type (e.g. swab) from source (e.g. leg wound)
- Collected at allows for some lab-to-lab reporting extra functions

**Cadham Provincial Laboratory Manitoba Health**

**General Requisition**

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Email: cadham@gov.mb.ca  
Website: www.gov.mb.ca/health/publichealth/pl

ADDRESSOGRAPH

<b>RELEVANT CLINICAL INFORMATION</b>		<b>PATIENT INFORMATION</b>	
Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured		PHIN: _____ MB Health Reg. # _____	
<b>Travel/Treatment History:</b>		Alternate ID: _____ <input type="checkbox"/> RCMP # _____ <input type="checkbox"/> Other Services/Territories _____	
<input type="checkbox"/> Autopsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Borne Illness <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Dialysis <input type="checkbox"/> Pregnant		<input type="checkbox"/> Military # _____	
<b>Signs and Symptoms:</b>		Date of Birth: _____ Sex: _____ Clinic/Lab # _____ YYYYMMDD M F U A	
<input type="checkbox"/> Bronchitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Rash <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Flu <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice		Patient Legal Name: Last _____ First Name _____	
Other: _____		Street or Other (e.g., Care Delivery) _____ Phone # _____	
<b>Reason for Test:</b>		City/Municipality and Nations Reserve _____ Postal Code _____	
<input type="checkbox"/> Immigration <input type="checkbox"/> Occupational <input type="checkbox"/> Other: _____ <input type="checkbox"/> Needlestick <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Mucosal		City/Municipality and Nations Reserve _____ Postal Code _____	
<b>SPECIMEN INFORMATION</b>		<b>RETURN REPORT TO:</b>	
Specimen Type: _____ Specimen Source: _____		Ordering Practitioner Last Name _____ First _____ Initial(s) _____	
Collected At: _____ Date/Time: _____		City _____	
<b>COPY REPORT TO:</b>		City Address _____ City/Town _____	
Ordering Practitioner Last Name _____ First Name _____		Postal Code _____ Phone # _____ Secure Fax # _____	
Facility _____ Secure Fax # _____			

**SEROLOGY**

**Serology Test Panels (1)**

Blood Borne Pathogen  Prenatal Panel  
 STI Panel  Prenatal HIV OPT OUT (2)  
 Post Exposure: Exposed Panel (4)  
 Post Exposure: Source Panel (14)  
 Other \_\_\_\_\_

**Rebovirus (4)**  Syphilis  Screen   
 HIV1/2Ab  HTLV1/2Ab  DFA

**Hepatitis**

HAV IgG (immunity)  Nucleic Acid (Plasma Only) (1)  
 HAV IgM  HBsAb (Immunity)  HCV PCR/Qual  WNV  
 HBcAb (IgM)  HBsAg  HCV PCR/Quant   
 HBcAb (Total)  HCV Ab  HCV Genotyping

**Miscellaneous Serology**

CMV  IgM  IgG Parvo B19  IgM  IgG  
EBV  IgM  IgG Rubella  IgM  IgG  
HSV  IgM  IgG Toxoplasma  IgM  IgG  
Measles  IgM  IgG Varicella  IgM  IgG  
Mumps  IgM  IgG WNV  IgM

Lyme Ab  Mycoplasma pneumoniae IgM

Name \_\_\_\_\_ PHIN \_\_\_\_\_

Name \_\_\_\_\_ PHIN \_\_\_\_\_

Specimen label stickers. Please fill one in and affix to the accompanying specimen container.

MG-696 (Rev. 05/10)

Collected At: \_\_\_\_\_ Date/Time: \_\_\_\_\_

**COPY REPORT TO:**

Ordering Practitioner Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Facility \_\_\_\_\_ Secure Fax # \_\_\_\_\_

- **COPY REPORT TO:**  
Allows practitioners to copy the report to another practitioner involved in the care of the patient

<b>SEROLOGY</b> <b>Serology Test Panels <sup>(1)</sup></b> <input type="checkbox"/> Blood Borne Pathogen <input type="checkbox"/> Prenatal Panel <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT <sup>(2)</sup> <input type="checkbox"/> Post Exposure: Exposed Panel <sup>(1)</sup> <input type="checkbox"/> Post Exposure: Source Panel <sup>(1,3)</sup> <input type="checkbox"/> Other _____		<b>PARASITOLOGY</b> <input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Pinworm Examination <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scrapings <input type="checkbox"/> Identification	
<b>Retrovirus <sup>(4)</sup></b> <input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HTLV1/2Ab		<b>Syphilis</b> <input type="checkbox"/> Screen <input type="checkbox"/> DFA	
<b>Hepatitis</b> <input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBsAb (Immunity) <input type="checkbox"/> HBcAb (IgM) <input type="checkbox"/> HBsAg <input type="checkbox"/> HBcAb (Total) <input type="checkbox"/> HCV Ab		<b>Nucleic Acid (Plasma Only)<sup>(5)</sup></b> <input type="checkbox"/> HBV PCR/Qual <input type="checkbox"/> WNV <input type="checkbox"/> HCV PCR/Qual <input type="checkbox"/> HCV PCR/Qual <input type="checkbox"/> HCV Genotyping	
<b>Miscellaneous Serology</b> CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG    Parvo B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG    Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG    Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG    Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG    WNV <input type="checkbox"/> IgM			
<input type="checkbox"/> Lyme Ab <input type="checkbox"/> Mycoplasma pneumoniae IgM			

**Cadham Provincial Laboratory Manitoba Health**  
**General Requisition**

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 Fax: (204) 786-4770  
 Email: cadham@gov.mb.ca  
 Website: www.gov.mb.ca/health/publichealth/lpi

**RELEVANT CLINICAL INFORMATION**  
 Outbreak Code:     In-Patient     Out-Patient     Urineur

**Travel/Treatment History:**

Autopsy     Diabetes     Food Borne Illness  
 Cancer/Chemotherapy     Dialysis     Pregnant

**Signs and Symptoms:**

Bronchitis     Fever     Lymphadenopathy  
 Conjunctivitis     Gastrointestinal     Pneumonia  
 Chest Pain     Headache     Rash  
 Diarrhea     Influenza-Like Illness     Sore Throat  
 Encephalitis     Jaundice

**Other:** \_\_\_\_\_

**Reason for Test:**  
 Immigration     Occupational     Other \_\_\_\_\_  
 Needlestick     Sexual Assault     Mucosal

**SPECIMEN INFORMATION**  
 Specimen Type: \_\_\_\_\_ Specimen Source: \_\_\_\_\_

Collected At: \_\_\_\_\_ Date/Time: \_\_\_\_\_ YYYYMMDD HHMM

**COPY REPORT TO:**  
 Ordering Practitioner Last Name    First Name    Facility Address    City/Town  
 Facility    Secure Fax #    Postal Code    Phone #    Secure Fax #

YY YMMDD    F U A

Patient Legal Name: Last \_\_\_\_\_

First Name \_\_\_\_\_

Street or Other (e.g. General Delivery) \_\_\_\_\_ Phone # \_\_\_\_\_

City/Municipality/First Nations Reserve \_\_\_\_\_ Postal Code \_\_\_\_\_

**RETURN REPORT TO:**  
 Ordering Practitioner Last Name    First    Initial(s)  
 Facility Address    City/Town  
 Postal Code    Phone #    Secure Fax #

# TICK-BOX MENU

- Not all inclusive
- “Other Tests or Requests” for tests without tick boxes

**Cadham Provincial Laboratory** **Manitoba** Health

**General Requisition**

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ONLY ONE SPECIMEN TYPE PER REQUISITION

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ADDRESSOGRAPH

<b>RELEVANT CLINICAL INFORMATION</b>		<b>PATIENT INFORMATION</b>	
Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured		PHIN: _____ MB Health Reg. # _____	
Travel/Treatment History:		Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Provinces/Territories	
<input type="checkbox"/> Autopsy <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis <input type="checkbox"/> Food Borne Illness <input type="checkbox"/> Pregnant		<input type="checkbox"/> Military # <input type="checkbox"/> Other _____	
Signs and Symptoms:		Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U <input type="checkbox"/> A Chart/Clinic/Lab # _____	
<input type="checkbox"/> Bronchitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice		Patient Legal Name: Last _____ First Name _____	
Other: _____		Street or Other (e.g., General Delivery) _____ # _____	
Reason for Test: <input type="checkbox"/> Immigration <input type="checkbox"/> Occupational <input type="checkbox"/> Other: _____ <input type="checkbox"/> Needlestick <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Mucosal		City/Municipality/First Nations Reserve _____ Postal Code _____	
<b>SPECIMEN INFORMATION</b>		<b>RETURN REPORT TO:</b>	
Specimen Type: _____ Specimen Source: _____		Ordering Practitioner Last Name _____ First _____ Initial(s) _____	
Collected At: _____ Date/Time: _____ YYYYMMDD HHMM		Facility _____	
<b>COPY REPORT TO:</b>		Facility Address _____ City/Town _____	
Ordering Practitioner Last Name _____ First Name _____		Postal Code _____ Phone # _____ Secure Fax # _____	
Facility _____ Secure Fax # _____		Postal Code _____ Phone # _____ Secure Fax # _____	
<b>SEROLOGY</b>		<b>PARASITOLOGY</b>	
Serology Test Panels (1) <input type="checkbox"/> Blood Borne Pathogen <input type="checkbox"/> Prenatal Panel <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT (2) <input type="checkbox"/> Post Exposure: Exposed Panel (1) <input type="checkbox"/> Post Exposure: Source Panel (1,3) <input type="checkbox"/> Other _____		<input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Pinworm Examination <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scrapings <input type="checkbox"/> Identification	
<input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HIV1/2Ag <input type="checkbox"/> DFA		<b>MICROBIOLOGY/BACTERIOLOGY</b>	
<b>Hepatitis</b> <input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> HBsAb (Immunity) <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> WNV <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBsAg <input type="checkbox"/> HCV PCR/Quant <input type="checkbox"/> WNV <input type="checkbox"/> HBcAb (IgM) <input type="checkbox"/> HBsAb <input type="checkbox"/> HCV Genotyping <input type="checkbox"/> HBcAb (Total) <input type="checkbox"/> HCV Ab		<input type="checkbox"/> Chlamydia and Gonorrhea (NAAT) <input type="checkbox"/> MRSA Screen <input type="checkbox"/> Chlamydia DFA (Microtrak) <input type="checkbox"/> VRE Screen <input type="checkbox"/> Fungus Culture <input type="checkbox"/> Clostridium difficile Toxin <input type="checkbox"/> GBS Prenatal Screen <input type="checkbox"/> Verotoxin Testing <input type="checkbox"/> Spore/Sterilizer Testing Referral Isolate: <input type="checkbox"/> Identification <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Subtyping Isolate Information: _____	
<b>Miscellaneous Serology</b> CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Parvo B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG WNV <input type="checkbox"/> IgM <input type="checkbox"/> Lyme Ab <input type="checkbox"/> Mycoplasma pneumoniae IgM		<b>VIRUS DETECTION</b> <input type="checkbox"/> Viral Studies <input type="checkbox"/> CMV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)	
Name _____ PHIN _____		<b>OTHER TESTS OR REQUESTS</b>	
Name _____ PHIN _____		_____	

**SEROLOGY**

**Serology Test Panels (1)**

Blood Borne Pathogen  Prenatal Panel  
 STI Panel  Prenatal HIV OPT OUT (2)  
 Post Exposure: Exposed Panel (1)  
 Post Exposure: Source Panel (1,3)  
 Other \_\_\_\_\_

**Detectovirus (4)** **Sunhilis**  Screen

# TEST PANELS

- Several panels of common combinations offered
- See back of the requisition for the details



- 1) **Test Panels (1): Prenatal** (HBsAg, Rubella IgG, Syphilis, HIV1/2 Ab); **Bloodborne** (HBsAg, HCV Ab, HIV1/2 Ab); **Serology STI** (HBsAg, HBsAb, Syphilis, HIV1/2 Ab); **Post Exposure – Exposed** (HBsAg, HCV Ab, HIV1/2 Ab, HBsAb); **Post Exposure – Source** (HBsAg; HCV Ab, HIV1/2 Ab).
- 2) **HIV Opt Out Box (2):** When this box is checked off, HIV antibody testing will not be conducted as part of the panel.
- 3) **Post Exposure Panels (3):** If T55 protocol is required, list T55 in the “Other” space under Post Exposure on the front of this form. The “Other” space can also be used if this testing is required due to a bite.

#### REQUISITION DEMOGRAPHIC INFORMATION

**Mandatory Fields:** The specimen will not be tested until all mandatory fields (Address, Source/Type) are provided.

**Alternate ID:** A unique health ID issued by other authorities such as: RCMP (PIN) this is a mandatory field

**Sex:** M = Male; F = Female; U = Unknown, A = Ambiguous (Transgender)

#### REPORTS

**Secure Fax Number:** The fax machine must be in a secure location accessible ONLY to persons handling reports.

**Report Address:** The address where the report(s) will be sent. Complete information including company name is required to ensure delivery. All reports will be sent by fax unless otherwise indicated.

**Copy Report To:** This area can only be filled out or authorized by the ordering practitioner and is intended for another practitioner providing care.

#### REQUISITION TEST ORDERING INFORMATION

**Outbreak Code:** For Infection Control and Public Health Purposes call Outbreak Coordinator (Microbiology Scientist) for code at (204) 945-7473.

**Specimen Type:** The nature of the specimen (e.g., aspirate, blood, tissue, swab, stool, urine, sputum, serum, plasma, CSF, etc.)

- 1) **Test Panels (1): Prenatal** (HBsAg, Rubella IgG, Syphilis, HIV1/2 Ab); **Bloodborne** (HBsAg, HCV Ab, HIV1/2 Ab); **Serology STI** (HBsAg, HBsAb, Syphilis, HIV1/2 Ab); **Post Exposure – Exposed** (HBsAg, HCV Ab, HIV1/2 Ab, HBsAb); **Post Exposure – Source** (HBsAg, HCV Ab, HIV1/2 Ab).
- 2) **HIV Opt Out Box (2):** When this box is checked off, HIV antibody testing will not be conducted as part of the panel.
- 3) **Post Exposure Panels (3):** If T55 protocol is required, list T55 in the “Other” space under Post Exposure on the front of this form. The “Other” space can also be used if this testing is required due to a bite.

- 5) **Nucleic Acid (N):** (Viral load) Send 10 cc EDTA whole blood (must be received within 6 hours at CPL) or EDTA plasma (stored at 2-8°C and received within 3 days at CPL). Please record on the front of this requisition the date and time of collection.

#### SPECIMEN COLLECTION INFORMATION

**Specimen Labelling:** Label specimen (blank stickers found on the front of this requisition may be used for this purpose) with patient's full name and PIN or alternate ID.

**Serology Specimen Volume Requirement:** 10 mL serum separator tube (full draw).

**Chlamydia and Gonorrhoea (NAAT Testing):**

**Endocervical Swab Specimens:** The cervical swab remains the specimen of choice for women. Use the Gen-Probe Aptima Unisex Swab Collection Kit.

**Urine:** Urine is the specimen of choice for males. It is the only recommended genital specimen for women without a cervix (hysterectomy) or those refusing a complete genital examination. The patient should not have urinated for at least one hour prior to sample collection. Use the Gen-Probe Aptima Urine Specimen Collection Unit.

**Male Urethral Swab Specimens:** Use the Gen-Probe Aptima Unisex Swab Collection Kit.

The following specimens are unsuitable for processing: 1) Urine specimens received with liquid levels not between the two black lines; 2) Swab specimen transport tubes containing no swab, the cleaning swab (white shaft), two swabs, or a swab not supplied by Gen-Probe; 3) Urine or Unisex Swab tubes with the foil cap missing or pierced; 4) Urine or swab specimens in tubes other than the Gen-Probe Aptima Collection tubes.

**Chlamydia DFA:** use for throat, rectal, eye, nasopharyngeal specimens.

For detailed specimen submission requirements and rejection policy, please consult our *Guide to Services* available online at: <http://www.gov.mb.ca/health/publichealth/cpl/documents.html> or call 204-945-6886 to order a copy of the Guide.

- Details on the Panels provided on back
- Note the HIV Opt Out panel. Mb recommends HIV testing for all pregnant women, thus “Prenatal Panel” is suggested.



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 Website: www.gov.mb.ca/health/publichealth/cpl

ADDRESSOGRAPH

<p><b>RELEVANT CLINICAL INFORMATION</b></p> <p>Outbreak Code: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured</p> <p><b>Travel/Treatment History:</b></p> <p><input type="checkbox"/> Autopsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Borne Illness  <input type="checkbox"/> Cancer/Chemotherapy <input type="checkbox"/> Dialysis <input type="checkbox"/> Pregnant</p> <p><b>Signs and Symptoms:</b></p> <p><input type="checkbox"/> Bronchitis <input type="checkbox"/> Fever <input type="checkbox"/> Lymphadenopathy  <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Rash  <input type="checkbox"/> Diarrhea <input type="checkbox"/> Influenza-Like Illness <input type="checkbox"/> Sore Throat  <input type="checkbox"/> Encephalitis <input type="checkbox"/> Jaundice</p> <p>Other: _____</p> <p><b>Reason for Test:</b></p> <p><input type="checkbox"/> Immigration <input type="checkbox"/> Occupational <input type="checkbox"/> Other:  <input type="checkbox"/> Needlestick <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Mucosal</p> <p><b>SPECIMEN INFORMATION</b></p> <p>Specimen Type: _____ Specimen Source: _____</p> <p>Collected At: _____ Date/Time: _____</p> <p><b>COPY REPORT TO:</b></p> <p>Ordering Practitioner Last Name _____ First Name _____</p> <p>Facility _____ Secure Fax # _____</p>	<p><b>PATIENT INFORMATION</b></p> <p>PHIN: _____ MB Health Reg. # _____</p> <p>Alternate ID: <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Province/Territories  <input type="checkbox"/> Military # <input type="checkbox"/> Other _____</p> <p>Date of Birth: _____ Sex: _____ Chart/Clinic/Lab # _____    YYYYMMDD M F U A</p> <p>Patient Legal Name: Last _____</p> <p>First Name _____</p> <p>Street or Other (e.g., General Delivery) _____ Phone # _____</p> <p>City/Municipality/First Nations Reserve _____ Postal Code _____</p> <p><b>RETURN REPORT TO:</b></p> <p>Ordering Practitioner Last Name _____ First _____ Initial(s) _____</p> <p>Facility _____</p> <p>Facility Address _____ City/Town _____</p> <p>Postal Code _____ Phone # _____ Secure Fax # _____</p>
<p><b>SEROLOGY</b></p> <p><b>Serology Test Panels (1)</b></p> <p><input type="checkbox"/> Blood Borne Pathogen <input type="checkbox"/> Prenatal Panel  <input type="checkbox"/> STI Panel <input type="checkbox"/> Prenatal HIV OPT OUT (2)  <input type="checkbox"/> Post Exposure: Exposed Panel (4)  <input type="checkbox"/> Post Exposure: Source Panel (1, 4)  <input type="checkbox"/> Other _____</p> <p><b>Retrovirus (4)</b> <input type="checkbox"/> Syphilis <input type="checkbox"/> Screen <input type="checkbox"/> DFA</p> <p><input type="checkbox"/> HIV1/2Ab <input type="checkbox"/> HTLV1/2Ab</p> <p><b>Hepatitis</b></p> <p><input type="checkbox"/> HAV IgG (immunity) <input type="checkbox"/> HBV PCR/Qual <input type="checkbox"/> WNV  <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBsAb (immunity) <input type="checkbox"/> HCV PCR/Qual  <input type="checkbox"/> HBcAb (IgM) <input type="checkbox"/> HBsAg <input type="checkbox"/> HCV PCR/Quant  <input type="checkbox"/> HBcAb (Total) <input type="checkbox"/> HCV Ab <input type="checkbox"/> HCV Genotyping</p> <p><b>Miscellaneous Serology</b></p> <p>CMV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Parvo B19 <input type="checkbox"/> IgM <input type="checkbox"/> IgG    EBV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Rubella <input type="checkbox"/> IgM <input type="checkbox"/> IgG    HSV <input type="checkbox"/> IgM <input type="checkbox"/> IgG Toxoplasma <input type="checkbox"/> IgM <input type="checkbox"/> IgG    Measles <input type="checkbox"/> IgM <input type="checkbox"/> IgG Varicella <input type="checkbox"/> IgM <input type="checkbox"/> IgG    Mumps <input type="checkbox"/> IgM <input type="checkbox"/> IgG WNV <input type="checkbox"/> IgM</p>	<p><b>PARASITOLOGY</b></p> <p><input type="checkbox"/> Ova &amp; Parasites <input type="checkbox"/> Pinworm Examination  <input type="checkbox"/> Blood Smears <input type="checkbox"/> Skin Scraping  <input type="checkbox"/> Identification</p> <p><b>MICROBIOLOGY/BACTERIOLOGY</b></p> <p><input type="checkbox"/> GAS <input type="checkbox"/> Chlamydia and Gonorrhea (NAAT)  <input type="checkbox"/> MRSA Screen <input type="checkbox"/> Mycoplasma DFA (Microtrak)  <input type="checkbox"/> VRE Screen <input type="checkbox"/> Fungus Culture  <input type="checkbox"/> Coarctum difficile Toxin <input type="checkbox"/> GAS Prenatal Screen  <input type="checkbox"/> Verotoxin Testing <input type="checkbox"/> Spore/Strep/Enteric Testing    Referral isolate: <input type="checkbox"/> Identification <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Subtyping</p> <p>Isolate Information: _____</p> <p><b>VIRUS DETECTION</b></p> <p><input type="checkbox"/> Viral Studies <input type="checkbox"/> HIV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)</p> <p><b>OTHER TESTS AND REQUESTS</b></p>

MD-498 (Rev. 06/09)  
 Specimen label stickers. Please fill one in and affix to the accompanying specimen container.

Name PHIN	Name PHIN
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CPL Sp act

## Stickers

- Meant to aid in specimen labelling or tracking in charts or log books
- Not required that these be used if specimen already labelled

#### REQUISITION DEMOGRAPHIC INFORMATION

**Mandatory Fields:** The specimen will not be tested until all mandatory fields (PHIN, Patient Legal Name, Date of Birth, Sex, Practitioner Name and Address, Source/Type) are provided.

**Alternate ID:** A unique health ID issued by other authorities such as: RCMP, Military, FNIH, Other Canadian Provinces, Great-West Life, etc. If no PHIN this is a mandatory field

**Sex:** M = Male; F = Female; U = Unknown; A = Ambiguous (Transgender)

#### REPORTS

**Secure Fax Number:** The fax machine must be in a secure location accessible ONLY to persons requiring reports.

**Report Address:** The address where the report(s) will be sent. Complete information including facility name is required to ensure delivery. All reports will be sent by fax unless otherwise indicated.

**Copy Report To:** This area can only be filled out or authorized by the ordering practitioner and is intended for another practitioner providing care.

#### REQUISITION TEST ORDERING INFORMATION

**Outbreak Code:** For Infection Control and Public Health Purposes call Outbreak Coordinator (Microbiology Scientist) for code at (204) 945-7473.

**Specimen Type:** The nature of the specimen (e.g., aspirate, blood, tissue/biopsy, stool, swab, urine, sputum, serum, plasma, CSF, etc.)

**Specimen Source:** The anatomical location or site (e.g., throat, right leg wound, etc.) from where the specimen was taken.

1) **Test Panels (T):** Prenatal (HBsAg, Rubella IgG, Syphilis, HIV1/2 Ab); Bloodborne (HBsAg, HCV Ab, HIV1/2 Ab); Serology STI (HBsAg, HBeAb, Syphilis, HIV1/2 Ab); Post Exposure – Exposed (HBsAg, HCV Ab, HIV1/2 Ab, HBeAb); Post Exposure – Source (HBsAg, HCV Ab, HIV1/2 Ab).

2) **HIV Opt Out Box (O):** When this box is checked off, HIV antibody testing will not be conducted as part of the panel.

3) **Post Exposure Panels (P):** If TSS protocol is required, list T55 in the "Other" space under Post Exposure on the front of this form. The "Other" space can also be used if this testing is required due to a bite.

4) **HIV (Retrovirus) (R):** For Non-Nominal HIV testing please use requisition MG #13396. For HIV Viral Load and Genotyping use requisition MG #5126 (Retrovirus Nucleic Acid Testing)

5) **Nucleic Acid (N):** (Viral load) Send 10 cc EDTA whole blood (must be received within 6 hours at CPL) or EDTA plasma (stored at 2-8°C and received within 3 days at CPL). Please record on the front of this requisition the date and time of collection.

#### SPECIMEN COLLECTION INFORMATION

**Specimen Labelling:** Label specimen (blank stickers found on the front of this requisition may be used for this purpose) with patient's full name and PHIN or alternate ID.

**Serology Specimen Volume Requirement:** 10 mL serum separator tube (full draw).

**Chlamydia and Gonorrhea (NAAT Testing):**

**Endocervical Swab Specimens:** The cervical swab remains the specimen of choice for women. Use the Gen-Probe Aptima Unisex Swab Collection Kit.

**Urine:** Urine is the specimen of choice for males. It is the only recommended genital specimen for women without a cervix (hysterectomy) or those refusing a complete genital examination. The patient should not have urinated for at least one hour prior to sample collection. Use the Gen-Probe Aptima Urine Specimen Collection Unit.

**Male Urethral Swab Specimens:** Use the Gen-Probe Aptima Unisex Swab Collection Kit.

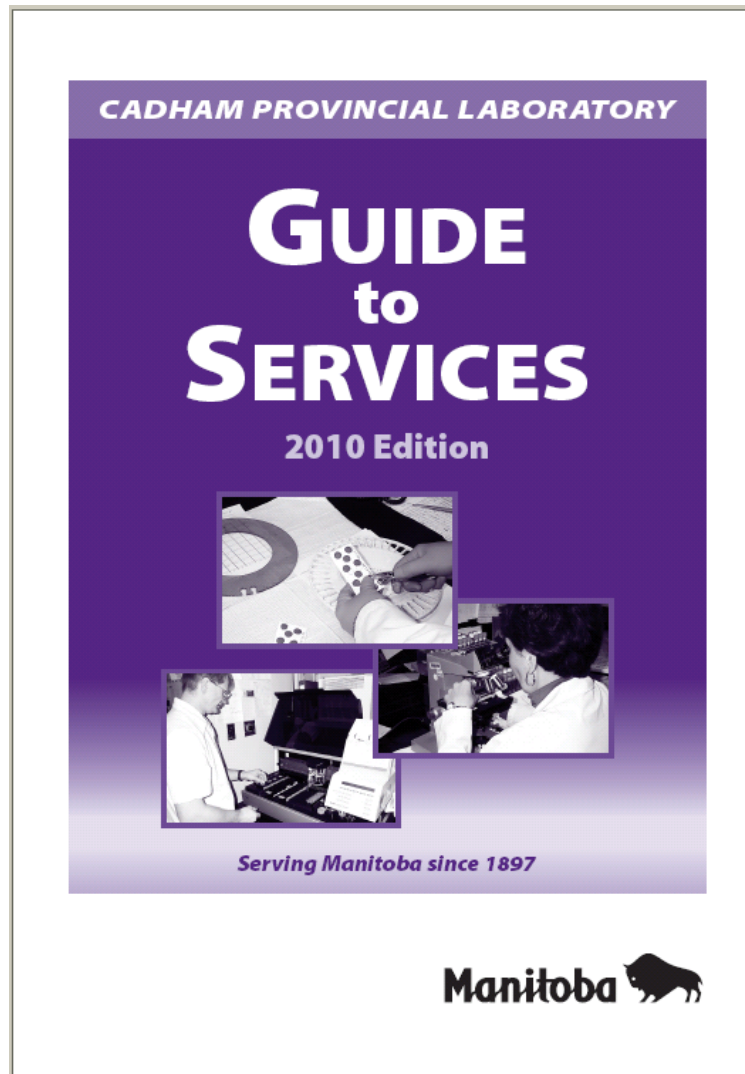
The following specimens are unsuitable for processing: 1) Urine specimens received with liquid levels not between the two black lines; 2) Swab specimen transport tubes containing no swab, the cleaning swab (white shaft), two swabs, or a swab not supplied by Gen-Probe; 3) Urine or Unisex Swab tubes with the foil cap missing or pierced; 4) Urine or swab specimens in tubes other than the Gen-Probe Aptima Collection tubes.

**Chlamydia DFA:** use for throat, rectal, eye, nasopharyngeal specimens.

For detailed specimen submission requirements and rejection policy, please consult our *Guide to Services* available online at: <http://www.gov.mb.ca/health/publichealth/cpl/documents.html> or call 204-945-6806 to order a copy of the Guide.

# Back of Requisition

- Contains specimen collection and labelling instructions as well as requisition instructions
- If not clear...



...call us, or refer to the online Guide to Services.  
Thank you