HUC Assignment # 5

PHYSICIANS' ORDER SHEET

Opportunity Medical Center
1912 Lake Pleasant Dr.
Pleasantville, Anystate 19480

DATE	TIME	SYMBOL	ORDERS
			Admit to med surg - pancreatitis
			VS q4h
			I&O
			Continuous IV D5 1/2 NS c 10 meq KCl
			@ 150 ml/hr
			Ambulatory
			H2O PO ad lib - otherwise NPO
			CBC/amylase/lipase early am
			[illegible]
			Demerol 75 mg IM q3° PRN sev pain
			Dr Edward Parson MD
			Tylenol X gr PO q4° if pt c/o H/A
			TO Dr Edward Parson/Joan Taylor RN
			Cepacol lozenges PRN
			UGI c SB [illegible] - carefully watch
			first swallow of contrast to
			r/o any extravasation → spoke
			to Dr Neuberg about this
			[illegible]
			CBC + diff, amylase + lipase
			in am
			Throat cx to rule out strep
			NPO for now
			Pepcid 20 mg IV BID
			Dr Edward Parson MD
			Sputum for AFB cx + stain
			Consent for EGD [illegible] Bx
			scheduled
			Dr Edward Parson MD

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Diagnosis

Admit Date to Family Medicine ____________

Admit Date to Hospital ____________

Past Hx

Risk Management:

Close Observation: ☐ q15 min ☐ q30 min

Side Rails ☐ 2 ☐ 3 ☐ 4

High Risk For: ☐ Falls ☐ Wandering

☐ Aggression

☐ Bed Check ☐ Chair Check

☐ Braden Scale # ________ Reassess ________

☐ Falls Risk Assess. #______ Reassess ________

Oriented: ☐ Person ☐ Place ☐ Time

Activity **Transfer Logo Updated** ☐ **Date** ______

☐ Self ☐ Assist: SBA ☐1 ☐2

☐ Hoyer ☐ Sara ☐ Mediman

☐ Bedrest ☐ BRP Only

☐ Turns ☐ Chair ____________

☐ Ambulate ☐ Walker ☐ Cane

☐ Physio ____________

ROM q ____________

☐ HOB Elevate ☐ FOB Elevate

Elimination:

☐ BR ☐ Bedpan ☐ Urinal

☐ Commode ☐ Foley ☐ Incontinent

☐ Brief ☐ Incl Pad

☐ Ostomy Change Bag ________

BM Due ____________

BR Routine ____________

☐ Bowel Sounds ____________

Allergies

Age:

Language Spoken:

Advance Care Plan

Review Date

____

Health Directive

☐ Yes ☐ No

Physician Consults

Contact:

Name: Relationship Phone

____________ H)________

W)________

____________ H)________

W)________

Hygiene

Bath: ☐ Self ☐ Assist ☐ Complete

Tub Day ________ ☐ Shower

☐ Dentures ____________

☐ Hearing Aids ________ ☐ Glasses

Vital Signs

Frequency ____________

☐ Crani Checks ____________

☐ Reassess ____________

Nutrition

☐ Weight ____________

Diet ____________

☐ NPO ☐ Self ☐ Assist ☐ Feed

☐ I/O ☐ Push Fluids

☐ Fluid Restrictions ________

☐ Crush Meds ________

☐ Tube Feed: ________

☐ Aspir. & Flush: ________

☐ NG Tube ☐ Low Suction

☐ Clamped ________

Change Bag ________

Intravenous Therapy

Site ________ Change ________

Sol'n/ Rate ________

Site ________ Change ________

Sol'n/Rate ________

TPN: Amino: ________

Lipids ________

☐ Heparin Protocol

PTT Due ________

☐ PICC Line ☐ Central Line

Line Drsg D/T → ________

Oxygenation

☐ O2 ________ ☐ O2 Sats ________

☐ Chest Sounds ________

☐ Chest Physio

☐ Suction ☐ DB &C

Other ________

Nursing Dx: Focus Update:	Nursing Interventions	Teaching/Goals/Additional Comments

Service Consult

- ☐ OT ____
- ☐ PT ____
- ☐ SW ____
- ☐ Speech ____
- ☐ Dietary ____
- ☐ Other ____

Dressings:

Drsg #1 Site ____

Type ____

Change ____

Drsg #2 Site ____

Type ____

Change ____

Drsg #3 Site ____

Type ____

Change ____

Sutures/Staples In ____ Out ____
Orthotics ____
Teds: On @ ____ Off @ ____
CWC( ) ____

Blood Work

Date	Type	Repeat

In House Tests:

Date	Type	Dept.

Referred Out Procedures:

Test ____ Date/Time ____
Facility ____ Trans. Time ____
Type of Trans ____
Escort: ☐ RN ☐ HCA ☐ Confirmed

Test ____ Date/Time ____
Facility ____ Trans. Time ____
Type of Trans ____
Escort: ☐ RN ☐ HCA ☐ Confirmed

Pass ☐ Yes ☐ No ☐ PRN
Date Ordered ____

Discharge Planning
☐ Home ☐ Home with Services
☐ Home Care Consult Date ____

Panelling
☐ Papers Completed ____
Panel Date ____

Med Card
☐ Yes ☐ No
Date Ordered ____
RX on Chart: ☐ Yes ☐ No
Own Meds: ☐ Yes ☐ No
Valuables: ☐ Yes ☐ No
Date Assessed: ____

Pacemaker: ☐ Yes ☐ No
Defibulator: ☐ Yes ☐ No
(If Yes mark in Red)

CONSENT TO OPERATION OR PROCEDURE

I, ______________________________________, hereby consent to undergo the operation or procedure of
(Patient's Full Name)

____

____ to be performed

or directed by Dr. ______________________________.
(Physician or Surgeon)

The nature, purpose and effects of this operation or procedure, as well as the attendant risks and alternatives, have been clearly and adequately explained to me by Dr. ______________________________.
(Physician or Surgeon)

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

I consent to such further extended or alternative operative measures as may be found necessary or advisable in my interest during the course of the above operation or procedure.

I consent to the administration of anaesthetics, drugs, blood, blood products, and monitoring devices considered necessary or advisable by the doctors in whose care I hereby place myself.

I consent to the assistance of other Hospital medical staff at the physician's discretion.

I agree to the disposal, by the Hospital, of any tissues or parts surgically removed.

I also hereby consent to the disclosure of information necessary to support claims for insurance and hospitalization benefits. I also agree that health records may be used for Continuous Improvement activities.

I CERTIFY THAT I HAVE READ/HAVE HAD READ/HAVE HAD INTERPRETED, AND FULLY UNDERSTAND THE ABOVE CONSENT FOR OPERATION OR PROCEDURE.

____
Witness to Signature of Patient or Person Providing Consent

____
Signature of Patient or Person Providing Consent

____
Date of Consent Time of Consent

____
Witness to Patient's mark (X) or Telephone Consent

____

____
Witness to Patient's mark (X) or Telephone Consent

____
Address of Witness if not Hospital Employee

____
Interpreter (if applicable)

If signed by a person other than the patient, complete the following:

The reason I am signing for the patient is: ______________________________

____

I provide this consent in my capacity of: Parent ☐ Guardian ☐ Spouse ☐ Other ☐ ____________ Next-of-kin ☐

CONSENT TO NON-USE OF BLOOD

I, ______________________________, request that no blood or blood products be administered to me
(Patient's Full Name)
during this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending medical practitioner or the Hospital staff to preserve life or promote recovery.

I release the Hospital and its staff and all physicians in any way connected with my treatment from any responsibility, whatsoever, for any untoward results due to my refusal to permit the use of blood or its derivatives.

____
Witness to Signature of Patient or Person Providing Consent

____
Signature of Patient or Person Providing Consent

____
Date of Consent Time of Consent

____

____
Interpreter (if applicable)

____
Address of Witness if not Hospital Employee

If signed by a person other than the patient, complete the following:

The reason I am signing for the patient is: ______________________________

I provide this consent in my capacity of: Parent ☐ Spouse ☐ Next-of-kin ☐ Guardian ☐ Other ☐ ______________________________

DIAGNOSTIC SERVICES OF MANITOBA | SERVICES DE DIAGNOSTIC DU MANITOBA

CLINICAL MICROBIOLOGY LABORATORY TEST REQUISITION

PLEASE COMPETE THE INFORMATION BELOW – PRINT CLEARLY

☐ Copy to

Name ______

Physician Code ______

Address ______

Fax # ______

Full name, address & fax number MUST be provided

PHN/Health Care Number | Chart # | Visit #

☐ M ☐ F | Patient Legal Name (Last) (First) (Initial) | Birth date DD MM YY

Ordering Address/Location | Physician Code

Report Address if Different

Collector | Date Specimen Collected DD MM YY | Time (24 h) | Ordering Physician/Practitioner

Diagnosis/Relevant Clinical Information:

☐ UTI symptoms (any of: flank pain, frequency, dysuria)
☐ Animal bite ☐ Human bite ☐ Diabetic ☐ Transplant ☐ Immunocompromised
☐ Post surgical ☐ Necrotizing fasciitis ☐ PID ☐ Pregnant ☐ Penicillin allergy
☐ History MRSA (+) ☐ Recent travel (last 2 years)

Diagnostic Information: ______

Antibiotic(s) - specify all antibiotics currently being received: ______

ONE SPECIMEN PER REQUISITION ONLY ☐ **STAT/URGENT (Microscopy only, where applicable)**

Blood and Other Sterile Fluids

☐ Blood culture ☐ Peripheral draw ☐ Central line draw
Site (specify) ______
☐ CSF
☐ Bone marrow
☐ Fluid (site) ______

Test:
☐ Bacterial culture - aerobic
☐ Bacterial culture - anaerobic
☐ Fungal culture
☐ Mycobacterial culture (AFB)

Other (specify site & test) ______

Urinary Tract Specimens

☐ MSU
☐ Catheter
☐ Suprapubic aspirate
☐ Cystoscopy
☐ Nephrostomy

Test:
☐ Bacterial culture - aerobic

Other (specify site & test) ______

Gastrointestinal Tract Specimens

☐ Stool culture
☐ Ova & Parasites
☐ *Clostridium difficile* toxin
☐ Stool - Mycobacterial culture (AFB)
☐ Gastric - wash Mycobacterial Culture (AFB)
☐ *H. pylori* (biopsy only)
☐ Pinworm exam

Other (specify site & test) ______

Genital Tract Specimens

Vagina
☐ Bacterial vaginosis/Vaginitis ☐ *Trichomonas vaginalis*

Vaginal/Rectal
☐ Grp B Strep Screen (pregnant only)

Cervix
☐ *N. gonorrhoeae* culture

Urethra
☐ N. gonorrhoeae culture

External Genital Specimen
☐ Vulva ☐ Penis
☐ Bacterial culture - aerobic

Respiratory Tract Specimens

Upper Respiratory Tract
☐ Throat
☐ Mouth culture (yeast only)
☐ Nose culture (*S. aureus* carrier only)
☐ Pertussis (nasopharyngeal swab, suction)
Other (specify site & test) ______

Lower Respiratory Tract
(must indicate Specimen/Source)
☐ Sputum expectorated
☐ ETT suction
☐ Bronchial wash ☐ *Legionella*
☐ BAL
☐ Lung biopsy/aspirate

Test:
☐ Bacterial culture - aerobic
☐ Fungal culture
☐ Mycobacterial culture (AFB)

Other (specify site & test) ______

Wounds/Skin/Abscesses/Surgical Specimens/Tissues

Specify site: ______

☐ Swab
☐ Tissue
☐ Biopsy
☐ IV catheter tips
☐ Ulcer
☐ Aspirate
☐ Bone chips
☐ Skin scrapings
☐ Foreign body

Test:
☐ Bacterial culture - aerobic
☐ Bacterial culture - anaerobic
☐ Fungal culture
☐ Mycobacterial culture (AFB)

Other (specify site & test) ______

Eyes and Ears

Eyes
☐ Left ☐ Conjunctiva
☐ Right ☐ Cornea

Ears
☐ Left ☐ External canal
☐ Right ☐ Perforated eardrum
☐ Middle ear drainage/fluid

Test:
☐ Bacterial culture - aerobic
☐ Fungal culture

Other (specify site & test) ______

Antibiotic Resistant Organisms

MRSA
☐ Nose
Other (specify site) ______

VRE
☐ Rectal
Other (specify site) ______

Other Specimens/Tests/Special Requests

Specimen ______ Specify site ______
Test(s) (specify) ______

Instructions to Complete

☐ Copy to Name ______ Physician Code ______ Address ______ Fax # ______ Full name, address & fax number MUST be provided	PHN/Health Care Number 123456789	Chart # 015368859-8	Visit # Lab N11485
	☐ M ☐ F Patient Legal Name (Last) Smith (First) John (Initial)		Birth date DD MM YY 26 11 1938
	Ordering Address/Location ED1		Physician Code
	Report Address if Different		
Collector	Date Specimen Collected DD MM YY 10 01 2010	Time (24 h) 1430	Ordering Physician/Practitioner Dr. S. Jones

The following information **must** be clearly provided on the requisition. (See DSM Specimen Acceptance Policy 10-50-03)

- **Patient name** (Last name, First name)
- **PHIN #/Chart #** (HSC medical records or PHIN for all non-HSC patients)
- **Date of Birth** (DD/MM/YY)
- **Patient location** (ward/clinic/nursing unit)
- **Ordering Physician/Practitioner**
- **Collection Date**

If another physician requires a copy of the report, the **Copy To** section **must** be completed with the physician's full name, location (address), and fax number.

Diagnosis/Relevant Clinical Information

Diagnosis/Relevant Clinical Information:

☐ UTI symptoms (any of: flank pain, frequency, dysuria)
☐ Animal bite ☐ Human bite
☐ Post surgical ☐ Necrotizing fasciitis
☐ Diabetic
☐ PID
☐ Transplant
☐ Pregnant
☐ History MRSA (+)
☐ Immunocompromised
☐ Penicillin allergy
☐ Recent travel (last 2 years)

Diagnostic Information: ______

Antibiotic(s) - specify all antibiotics currently being received: ______

All information available in relation to the patient as outlined in this section must be entered. This information will be used by the laboratory to determine how the sample is processed. Failure to provide such information may result in sub-optimal sample workup.

Ordering Tests

- To order a test, place an "X" in the box that describes the specimen being sent, and the test being ordered.

Examples: Right hip swab for C&S

Wounds/Skin/Abscesses/Surgical Specimens/Tissues

Specify site: R. Hip

☒ **Swab**
☐ Tissue
☐ Biopsy
☐ IV catheter tips
☐ Ulcer
☐ Aspirate
☐ Bone chips
☐ Skin scrapings
☐ Foreign body

Test:
☒ **Bacterial culture - aerobic**
☐ Bacterial culture - anaerobic
☐ Fungal culture
☐ Mycobacterial culture (AFB)

Other (specify site & test) ______

MSU for C&S

Urinary Tract Specimens

☒ **MSU**
☐ Catheter
☐ Suprapubic aspirate
☐ Cystoscopy
☐ Nephrostomy

Test:
☒ **Bacterial culture - aerobic**

Other (specify site & test) ______

Notes

- C&S is a term no longer used. The term "Bacterial culture-aerobic" in the test request area on the requisition is synonymous with C&S
- "Bacterial culture-anaerobic" is **only** requested when the ordering physician is specifically suspecting anaerobic organisms. *please supply relevant clinical information with this request.
- Tests done by Cadham Provincial Laboratory continue to require a Cadham Laboratory requisition. (Please refer to DSM Lab Information Manual on HSC website)

ROBERTSON GENERAL HOSPITAL

SCHEDULED MEDICATIONS

ALLERGIES: ______________________________

ORDER DATE	REORDER DATE	START DATE	STOP DATE	SCHEDULE	MEDICATION/DOSE/ROUTE	YEAR					
			RN			DATE	DATE	DATE	DATE	DATE	DATE
						TIME INIT.	TIME INIT.	TIME INIT.	TIME INIT.	TIME INIT.	TIME INIT.

ROBERTSON GENERAL HOSPITAL

NON-SCHEDULED MEDICATIONS

ALLERGIES: ____________________

NONRECURRING MEDICATION	RN	DATE TIME	START DATE RN	STOP DATE RN	PRN MEDICATIONS	YEAR DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.

STATS and NON-RECURRING MEDICATIONS

MEDICATION ADMINISTRATION RECORD (MAR)

Wt ____________ Refer to: ☐ Diabetic Flowsheet
☐ ICU Flowsheet
☐ Epidural Flowsheet
☐ PCA Flowsheet

DATE
PATIENT
DOB
PROV HC#
DOCTOR
CLINIC/UNIT LOC'N

ALLERGIES:

MEDICATION ORDERED YEAR 20____							MEDICATION GIVEN	
DATE DD/MONTH / TIME	MEDICATION				INITIALS		DATE (IF DIFFERENT) / TIME	INITIALS
	NAME	DOSE	ROUTE	INSTRUCTIONS	TRAN-SCRIBER	NURSE		GIVEN BY / 2ND IF NEEDED

STATS and NON-RECURRING MEDICATIONS
MEDICATION ADMINISTRATION RECORD (MAR)

Wt ____________ Refer to: ☐ Diabetic Flowsheet
☐ ICU Flowsheet
☐ Epidural Flowsheet
☐ PCA Flowsheet

DATE
PATIENT
DOB
PROV HC#
DOCTOR
CLINIC/UNIT LOC'N

ALLERGIES:

MEDICATION ORDERED YEAR 20 ___							MEDICATION GIVEN	
DATE DD/MONTH / TIME	MEDICATION				INITIALS		DATE (IF DIFFERENT) / TIME	INITIALS
	NAME	DOSE	ROUTE	INSTRUCTIONS	TRAN-SCRIBER	NURSE		GIVEN BY / 2ND IF NEEDED

*** PLEASE COMPLETE THE INFORMATION BELOW, PRINT CLEARLY ***

NAME OF PHYSICIAN ORDERING TEST: .... (LAST) .... (FIRST)

REFERRING INSTITUTION NAME AND ADDRESS OR CODE:

IF AN ADDITIONAL REPORT IS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

PHYSICIAN NAME: ....

ADDRESS: ....

CITY: .... PROV. ...... POSTAL CODE ....

TELEPHONE NO. .... FAX NO. ....

ENCOUNTER NO.: .... LOCATION (WARD/CLINIC): ....

PATIENT NAME: .... (LAST) .... (FIRST)

DATE OF BIRTH: .... DD/MM/YYYY SEX: ☐ F ☐ M

FACILITY PATIENT ID NO.: ....

PHIN (9 DIGITS): ....

PHYSICIAN/PHYSICIAN NO.: ....

COLLECTION DATE: ....

COLLECTION TIME: ....

COLLECTED BY: ....

SPECIMEN ID #
HSC LAB USE ONLY

SCHEDULED COLLECTION: DATE: ______ TIME: ☐ 0800 ☐ OTHER: ______ COLLECTED BY: ☐ VENIPUNCTURE ☐ INDWELLING LINE ☐ ABOVE SHUT-OFF IV

CHEMISTRY		CHEMISTRY		CHEMISTRY		ENDOCRINE TESTS	
Sodium	NA	Alkaline Phosphatase	ALK	Ammonia Send on ice	AMM	ACTH Send on ice	ACTH
Potassium	K	ALT (SGPT)	ALT	Angiotensin Conv. Enz.	ACE	Cortisol	COR
Chloride	CL	AST (SGOT)	AST	Beta-Hydroxybutyrate	BHB	DHAS	DHAS
Total CO_2 (Bicarbonate)	CO2	Bilirubin, Total	TB	Ceruloplasmin	CERU	Estradiol	E2
Glucose	G	Bilirubin, Direct	DB	Ethanol	ETO	FSH	FSH
Urea	U	γ-Glutamyl Transferase	GGT	FEP	FEP	Growth Hormone	GH
Creatinine	CR	LD	LD	Ferritin	FER	HCG (Quantitative)	HCGQ
Calcium	CA	Lipase	LIP	Glycated Hemoglobin	GYHB	17-Hydroxyprogesterone	PR17
Phosphate	P	Uric Acid	UA	Haptoglobin	HPT	Insulin	INS
Magnesium	MG	Iron	IRON	Homocysteine Send on ice	HCQ	LH	LH
CK	CK	TIBC	TIBC	IgE	IGE	Progesterone	PGN
Troponin T	TNT	Osmolality	OS	Ionized Calcium	ICA	Prolactin	PL
Myoglobin	SMYO	Alpha-Fetoprotein	AFP	Lactic Acid Send on ice	LAC	SHBG	SHBG
Total Protein	TP	Beta-2 Microglobulin	B2M	Lead	PB	Testosterone	TST
Albumin	AL	CA125	CA1	Prealbumin	PALB	FAI	FAI
Lipoprotein Profile (Includes CH, TG, HDL, LDL)	LIPP	CA 15-3	CA15	PTH Send on ice	PTH	T3, Free	FT3
		CA 19-9	CA19	Vitamin B12	B12	T4, Free	FT4
Cholesterol	CH	Carcinoembryonic Antigen	CEA	Vitamin D25	D25	TSH	TSH
Triglyceride	TG	PSA	PRSA	Zinc	ZN	Thyroperoxidase Antibodies	TPO

HEMATOPATHOLOGY	
Complete Blood Count (includes 5 cell differential)	CBC
Blood Film Review (**Reason must be given**) Reason:	SLR
Reticulocyte Count	RETA
Sedimentation Rate (ESR)	ESR
Sickle Cell Screen	HSS
Malaria	MAL
Cold Agglutinin Screen	HCA
Glucose-6-Phosphate Dehydrogenase	GPD
PT/INR/Pfib	PT
APTT	APTT
Fibrinogen	CFIB
D-Dimer (Qualitative)	DDIM
Lupus Inhibitor	LUPS
Factor V Leiden	MOL
Prothrombin Variation (G20210A)	MOL
Heinz Body Screen	HBA

DRUG LEVELS			
Acetaminophen	ACTM	Mycophenolic Acid	MPA
Amiodarone	AMIO	Phenobarbital	PHEN
Carbamazepine	CARB	Phenytoin	PYN
Cyclosporin	CY	Salicylate	SAL
Digoxin	DIG	Sirolimus	SIRO
FK506	FK5	Theophylline	TEO
Gentamicin	GENT	Tobramycin	TOBR
Lithium	LI	Valproic Acid	VALP
Methotrexate	MTX	Vancomycin	VANC

LAST DOSE: TIME: DATE: (D/M/Y)

NEXT DOSE: TIME: DATE: (D/M/Y)

IV FINISH: TIME:

SPECIMEN COLLECTION INSTRUCTIONS

Tests marked in red require special collection and/or transport. Consult the Lab Information Manual or call the laboratory.

OTHER TESTS (Please Print)

CLINICAL INFORMATION

URGENT

CHEMISTRY/HEMATOPATHOLOGY TEST REQUISITION

LABORATORY TEST REQUEST BLOOD, SERUM OR PLASMA

FORM # 85464 01/06

*** PLEASE COMPLETE THE INFORMATION BELOW, PRINT CLEARLY ***

NAME OF PHYSICIAN ORDERING TEST: .... (LAST) .... (FIRST)

REFERRING INSTITUTION NAME AND ADDRESS OR CODE:

IF AN ADDITIONAL REPORT IS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

PHYSICIAN NAME: ....

ADDRESS: ....

CITY: .... PROV. .... POSTAL CODE ....

TELEPHONE NO. .... FAX NO. ....

ENCOUNTER NO.: .... LOCATION (WARD/CLINIC): ....

PATIENT NAME: .... (LAST) .... (FIRST)

DATE OF BIRTH: .... DD/MM/YYYY SEX: ☐ F ☐ M

FACILITY PATIENT ID NO.: ....

PHIN (9 DIGITS): ....

PHYSICIAN/PHYSICIAN NO.: ....

COLLECTION DATE: ....

COLLECTION TIME: ....

COLLECTED BY: ....

SPECIMEN ID # KHC LAB USE ONLY

TIMED COLLECTIONS: START DATE/TIME: ______ STOP DATE/TIME: ______

VOLUME: ______ mL

URINE		CSF	
Sodium	NAU	Cell Count & Differential	CSFH
Potassium	KU	Chloride	CLC
Creatinine	CRU	Glucose	GLC
Osmolality	OSU	Protein, Total	PC
Albumin	UALB		
Calcium	* CAU	**FLUIDS**	
Chloride	CLU	Type ______	
Citrate	* CITU	Cell Count & Differential	HFLD
Cortisol	* CORU	Crystals	CRYS
Creatinine Clearance	CRCL	Fetal Lung Maturity	LP
Ht. ______ cm Wt. ______ kg		Fluid for Eosinophils	FFE
Homovanillic Acid	* HVA	Albumin	ALFL
Hydroxyindole Acetic Acid	* HIAA	Bilirubin, Total	BFL
Metanephrines	* MNPH	Chloride	CLFL
Oxalate	* OXU	Creatinine	CRFL
Phosphate	POU	Glucose	GFL
Porphobilinogen	* PBG	LD	LDFL
Porphyrins	* POR	Lipase	LPFL
Pregnancy Test	PREG	Potassium	KFL
Protein, Total	TPU	Protein, Total	TPFL
Urea	UU	Sodium	NAFL
Uric Acid	UAU	Urea	UFL
Urobilinogen	* UBGQ	Uric Acid	UAFL
Vanillymandelic Acid	* VMA	**STOOL**	
		Fat (Quantitative)	* FF
Urinalysis (Dipstick)	UR	Natural & Split Fats	FECA
Urine Microscopic Review **Reason must be given** Reason:	RFM	Occult Blood	OB
		pH	* PHF
		Reducing Substances	* RSF
		Stool for Leukocytes	SFL

SPECIAL INVESTIGATIONS

(Appropriate clinical data must be completed)

Metabolic Screen	1 mL blood (fasting)	Plasma	AAQP
	plus 20 mL urine	Urine	METU

Time blood drawn ______

Time of last feed ______

History ______

Clinical/Lab Findings ______

Other Information ______

SPECIMEN COLLECTION INSTRUCTIONS

Tests marked in * require special collection and/or transport. Consult the Lab Information Manual or call the Laboratory.

OTHER TESTS (Please Print)

URGENT

CHEMISTRY / HEMATOPATHOLOGY TEST REQUISITION

LABORATORY TEST REQUEST MISCELLANEOUS

s an operating division of the Winnipeg Regional Health Authority

DIAGNOSTIC SERVICES OF MANITOBA | SERVICES DE DIAGNOSTIC DU MANITOBA

CLINICAL MICROBIOLOGY LABORATORY TEST REQUISITION

PLEASE COMPETE THE INFORMATION BELOW – PRINT CLEARLY

☐ Copy to

Name ______

Physician Code ______

Address ______

Fax # ______

Full name, address & fax number MUST be provided

PHN/Health Care Number | Chart # | Visit #

☐ M ☐ F | Patient Legal Name (Last) (First) (Initial) | Birth date DD MM YY

Ordering Address/Location | Physician Code

Report Address if Different

Collector | Date Specimen Collected DD MM YY | Time (24 h) | Ordering Physician/Practitioner

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☐ STAT/URGENT (Microscopy only, where applicable)

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Site (specify) ______

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☐ Bone marrow
☐ Fluid (site) ______

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Urinary Tract Specimens

☐ MSU
☐ Catheter
☐ Suprapubic aspirate
☐ Cystoscopy
☐ Nephrostomy

Test:
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Other (specify site & test) ______

Gastrointestinal Tract Specimens

☐ Stool culture
☐ Ova & Parasites
☐ *Clostridium difficile* toxin
☐ Stool - Mycobacterial culture (AFB)
☐ Gastric - wash Mycobacterial Culture (AFB)
☐ *H. pylori* (biopsy only)
☐ Pinworm exam

Other (specify site & test) ______

Genital Tract Specimens

Vagina
☐ Bacterial vaginosis/Vaginitis ☐ *Trichomonas vaginalis*

Vaginal/Rectal
☐ Grp B Strep Screen (pregnant only)

Cervix
☐ *N. gonorrhoeae* culture

Urethra
☐ N. gonorrhoeae culture

External Genital Specimen
☐ Vulva ☐ Penis
☐ Bacterial culture - aerobic

Respiratory Tract Specimens

Upper Respiratory Tract
☐ Throat
☐ Mouth culture (yeast only)
☐ Nose culture (*S. aureus* carrier only)
☐ Pertussis (nasopharyngeal swab, suction)

Other (specify site & test) ______

Lower Respiratory Tract
(must indicate Specimen/Source)
☐ Sputum expectorated
☐ ETT suction
☐ Bronchial wash ☐ *Legionella*
☐ BAL
☐ Lung biopsy/aspirate

Test:
☐ Bacterial culture - aerobic
☐ Fungal culture
☐ Mycobacterial culture (AFB)

Other (specify site & test) ______

Wounds/Skin/Abscesses/Surgical Specimens/Tissues

Specify site: ______

☐ Swab
☐ Tissue
☐ Biopsy
☐ IV catheter tips
☐ Ulcer
☐ Aspirate
☐ Bone chips
☐ Skin scrapings
☐ Foreign body

Test:
☐ Bacterial culture - aerobic
☐ Bacterial culture - anaerobic
☐ Fungal culture
☐ Mycobacterial culture (AFB)

Other (specify site & test) ______

Eyes and Ears

Eyes
☐ Left ☐ Conjunctiva
☐ Right ☐ Cornea

Ears
☐ Left ☐ External canal
☐ Right ☐ Perforated eardrum
☐ Middle ear drainage/fluid

Test:
☐ Bacterial culture - aerobic
☐ Fungal culture

Other (specify site & test) ______

Antibiotic Resistant Organisms

MRSA
☐ Nose
Other (specify site) ______

VRE
☐ Rectal
Other (specify site) ______

Other Specimens/Tests/Special Requests

Specimen ______ Specify site ______

Test(s) (specify) ______

Instructions to Complete

☐ Copy to Name ______ Physician Code ______ Address ______ Fax # ______ Full name, address & fax number MUST be provided	PHN/Health Care Number 123456789	Chart # 015368859-8	Visit # Lab N11485
	☐ M ☐ F	Patient Legal Name (Last) Smith (First) John (Initial)	Birth date DD MM YY 26 11 1938
	Ordering Address/Location ED1		Physician Code
	Report Address if Different		
Collector	Date Specimen Collected DD MM YY 10 01 2010	Time (24 h) 1430	Ordering Physician/Practitioner Dr. S. Jones

The following information **must** be clearly provided on the requisition. (See DSM Specimen Acceptance Policy 10-50-03)

- **Patient name** (Last name, First name)
- **PHIN #/Chart #** (HSC medical records or PHIN for all non-HSC patients)
- **Date of Birth** (DD/MM/YY)
- **Patient location** (ward/clinic/nursing unit)
- **Ordering Physician/Practitioner**
- **Collection Date**

If another physician requires a copy of the report, the **Copy To** section **must** be completed with the physician's full name, location (address), and fax number.

Diagnosis/Relevant Clinical Information

Diagnosis/Relevant Clinical Information:

☐ UTI symptoms (any of: flank pain, frequency, dysuria)
☐ Animal bite ☐ Human bite ☐ Diabetic ☐ Transplant ☐ Immunocompromised
☐ Post surgical ☐ Necrotizing fasciitis ☐ PID ☐ Pregnant ☐ Penicillin allergy
☐ History MRSA (+) ☐ Recent travel (last 2 years)

Diagnostic Information: ______

Antibiotic(s) - specify all antibiotics currently being received: ______

All information available in relation to the patient as outlined in this section must be entered. This information will be used by the laboratory to determine how the sample is processed. Failure to provide such information may result in sub-optimal sample workup.

Ordering Tests

- To order a test, place an "X" in the box that describes the specimen being sent, and the test being ordered.

Examples: Right hip swab for C&S

Wounds/Skin/Abscesses/Surgical Specimens/Tissues

Specify site: R. Hip

☒ **Swab**
☐ Tissue
☐ Biopsy
☐ IV catheter tips
☐ Ulcer
☐ Aspirate
☐ Bone chips
☐ Skin scrapings
☐ Foreign body

Test:
☒ **Bacterial culture - aerobic**
☐ Bacterial culture - anaerobic
☐ Fungal culture
☐ Mycobacterial culture (AFB)

Other (specify site & test) ______

MSU for C&S

Urinary Tract Specimens

☒ **MSU**
☐ Catheter
☐ Suprapubic aspirate
☐ Cystoscopy
☐ Nephrostomy

Test:
☒ **Bacterial culture - aerobic**

Other (specify site & test) ______

Notes

- C&S is a term no longer used. The term "Bacterial culture-aerobic" in the test request area on the requisition is synonymous with C&S
- "Bacterial culture-anaerobic" is **only** requested when the ordering physician is specifically suspecting anaerobic organisms. *please supply relevant clinical information with this request.
- Tests done by Cadham Provincial Laboratory continue to require a Cadham Laboratory requisition. (Please refer to DSM Lab Information Manual on HSC website)

DATE

PATIENT

DOB

PROV HC#

DOCTOR

CLINIC/UNIT LOC'N

REQUEST FOR CONSULTATION FOR DIAGNOSTIC IMAGING EXAM

☐ Outpatient
☐ First Available Site Fax to Access Centre 787-8910
or
☐ Preferred Site(s) ______________ (see reverse)

☐ ER
☐ Inpatient ______________ (Site and Unit)

Date Exam Needed: ______ ACP #: ______

PATIENT INFORMATION

PHIN ______________ Sex ☐ Male ☐ Female

Other Insurance No. ______________ WCB # ______________

Address ______________

City ______________ Province ______ Postal Code ______________

Phone Home ( ) ______________ Work ( ) ______________ Cell ( ) ______________

Emergency Contact/Next of Kin ______________ Maiden Name ______________

HISTORY AND EXAMINATION REQUESTED

(See WRHA website for additional information and forms for Breast U/S; PET; Mammography, Bone Density)

Modality Requested (select one)

☐ X-Ray ☐ Ultrasound ☐ CT ☐ Nuclear Medicine ☐ MRI

METHOD OF TRANSPORT

☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Portable

☐ Gerichair ☐ Bed ☐ Will Require Lift

Examination Requested

☐ Elective
☐ Urgent

*Note: For *emergent* outpatient exams, Radiologist must be contacted directly

Previous Relevant Exams	Date	Location
1.		
2.		
3.		

History and Provisional Diagnosis. Patient on Infection Control Precautions? Specify

MUST COMPLETE FOR ALL EXAMS

Patient Weight ______________

Patient Height ______________

Is patient pregnant? ☐ Yes ☐ No

LNMP ______ / ______ / ______ (dd mm yy)

Is patient nursing? ☐ Yes ☐ No

For invasive procedures:

INR (within 24 hours of exam) ______________

Platelets (within 24 hours of exam) ______________

FOR CONTRAST ENHANCED EXAMS

If contrast media is required, no solid food 4 hours prior to study. Normal fluid intake. If the patient is diabetic, please adjust medication accordingly.

"Allergy" to X-Ray dye ☐ Yes ☐ No

Contrast media can reduce renal function in patients with the following risk factors: *(check all that apply)*

☐ Kidney Disease ☐ Collagen Vascular Disease ☐ Receiving Metformin, Interleukin, NSAIDs

☐ Diabetes ☐ Myeloma ☐ Age > 65 years

For these "at risk" patients:

- **provide Serum Creatinine (within 90 days of exam or 30 days if known renal disease)** ______
- consider stopping NSAIDs, ACE inhibitors or other nephrotoxic medications prior to the procedures.
- stop Metformin 48 hours following IV contrast injection and check renal function prior to re-initiating medication.

MUST COMPLETE FOR ALL MRI EXAMS

Cardiac Pacemaker ☐ Yes ☐ No **If yes, patient cannot be scanned.**

For contrast enhanced exams:

☐ Patient on hemodialysis
☐ Patient on peritoneal dialysis
☐ Serum Creatine > 250 umol/L or GFR < 30 mL/min

Check conditions that apply:

☐ Heart Valve
☐ Aneurysm surgery or aneurysm clips. If yes, forward OR report prior to MRI exam.
☐ Implanted Devices; i.e. stimulators, shunts, electrodes, pumps, Strata valves, inner ear implants etc.
☐ Claustrophobic, and/or other medical condition that requires sedation.
☐ Metal in eyes or previous eye surgery. If yes, forward orbit x-ray report prior to exam.
☐ Patient cannot lie supine for 30 minutes.

PEDIATRIC MRI PATIENTS ONLY:

Gastroesophageal Reflux ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
Abnormal Airway ☐ Yes ☐ No
Chronic Chest Infections ☐ Yes ☐ No
Neuromuscular Problems ☐ Yes ☐ No
Pediatric Head Circumference ______________

AUTHORIZED CLINICIAN INFORMATION

Signature (Print and Sign) ______________ MHSC Billing # ______________

Address ______________ Phone # ______________ Fax # ______________ Date ______________

Extra Report To: ______________ Name/Address/Phone Fax # ______________

Office Use Only Coding

Appointment Date/Time ______________

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CONTACT LIST

Fax and Contact Phone Numbers

	Fax #	Phone #
DI Access Centre	787-8910	787-8907
(For First Available Appointment)		
Breast Health Centre	231-3839	235-3626
Concordia Hospital		
CT/Ultrasound	661-7329	661-7436
Fluoroscopy	661-7329	661-7436
X-Ray	654-3884	661-7212
Deer Lodge Centre	832-0619	831-2158
Grace Hospital		
CT/Ultrasound	837-0586	837-0171
Nuclear Medicine	837-0586	837-0179
X-Ray/Fluoroscopy	837-0586	837-0806
Health Sciences Centre		
Angiography	787-3193	787-7620
CT	787-7295	787-3053
Fluoroscopy	787-7482	787-4630
Mammography	787-3558	787-5050
MRI	787-3118	787-1323
Nuclear Medicine	787-3090	787-3375
PET	787-3300	787-3122
Ultrasound	787-3355	787-3076
X-Ray	787-3558	787-3241
Health Sciences Centre - Child Health		
Pediatric CT	787-4808	787-4800
Pediatric Nuclear Med	787-3090	787-3375
Pediatric US	787-4808	787-4800
Pediatric X-Ray/Fluoroscopy	787-1439	787-2288

	Fax #	Contac
Misericordia Health Centre		
CT	772-6748	788-8264
Ultrasound	772-6748	788-8267
X-Ray/Fluoroscopy	772-6748	788-8266
Pan Am (MRI)	927-2686	927-2674
Riverview Health Centre	478-6273	478-6123
St. Boniface General Hospital		
Angiography	237-7439	237-2526
CT	233-6377	235-3150
Mammography	237-7439	237-2526
MRI	233-2777	235-3600
Nuclear Medicine	237-2007	237-2748
Ultrasound	231-0355	237-2531
X-Ray/Fluoroscopy	237-7439	237-2526
Seven Oaks General Hospital		
CT	694-9323	632-31
Nuclear Medicine	694-9323	632-328
Ultrasound/Fluoroscopy/X-Ray	694-9323	632-3526
Victoria General Hospital		
CT/Fluoroscopy/X-Ray	269-7723	477-3179
Nuclear Medicine	269-7723	477-3175
Ultrasound	269-7723	477-3132

WRHA Webpage for Diagnostic Imaging Requisition Forms:
www.wrha.mb.ca/prog/diagnostic/forms.php