HUC-CLASS ASSIGNMENT #1

PHYSICIANS' ORDER SHEET

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

DATE	TIME	SYMBOL	ORDERS
			admit to pulmonary unit
			Dx: COPD c̄ Diabetes
			Allergies: Iodine & fish
			CBR - semi fowlers position
			May use BSC if need
			1200 cal ADA diet - NAS
			HS snack - dietician to consult
			IV of 1000ml Isolyte M c̄ 40 mEq KCL
			@ 120ml/hr
			Lasix 40mg IV push now, then 20mg PO qDay
			Lente insulin 40 units q AM
			Tylenol c̄ cod ii PO q 3-4° prn HA
			Tigan 250 mg supp prn N
			Demerol 50mg IM q 4-6° prn pain
			Restoril 30mg po q HS
			Stat CBC c̄ lytes & RBS
			CMP in AM - FBS daily
			UA
			Chest PA & lat - r/o pneumonia
			ABG on RA now, then place on O_2
			@ 2 L/min NP
			SVN c̄ 0.5ml Ventolin in 2ml NS q 4°
			c̄ CPT
			Accucheck AC & HS - call hospitalist
			if > 250
			Dr. Mary Logan PA
			Turn pt q 2°
			Dr. John Cohen MD

Copyright © 2014, 2009, 2004, 1998, 1993, 1986, 1979 by Saunders, an imprint of Elsevier Inc.

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 ________________________

NS-0060 01/04

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)

☐ TO CONSULT
☐ TO TAKE OVER
☐ FOR INFORMATION

USE THIS AREA WHEN REFERRING TO AMBULATORY CARE
FROM .... AREA/CLINIC .... CENTRE
TO .... CLINIC-APPT. DATE ....
PATIENT'S PHONE NUMBER ....

DATE

PATIENT

DOB

PROV HC#

DOCTOR

CLINIC/UNIT LOC'N

Doctor and/or Service .... Date ....

Your opinion is sought regarding ....

....

....

....

....

Signed Dr. ....

CONSULTANT'S REPORT Date ....

To Doctor: .... Hour ....

....

....

....

....

....

....

....

....

....

....

....

Take Over Accepted ☐ Yes ☐ No
Transfer to Appropriate Ward ☐ Yes ☐ No

Signed Dr. ....

☐ TO CONSULT
☐ TO TAKE OVER
☐ FOR INFORMATION

USE THIS AREA WHEN REFERRING TO AMBULATORY CARE	
FROM .... AREA/CLINIC	.... CENTRE
TO .... CLINIC-APPT. DATE	....
PATIENT'S PHONE NUMBER	....

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

Doctor and/or Service .... Date ....

Your opinion is sought regarding ....

....

....

....

....

Signed Dr. ....

CONSULTANT'S REPORT Date ....

To Doctor: .... Hour ....

....

....

....

....

....

....

....

....

....

....

....

Take Over Accepted ☐ Yes ☐ No
Transfer to Appropriate Ward ☐ Yes ☐ No

Signed Dr. ....

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

ROBERTSON GENERAL HOSPITAL

SCHEDULED MEDICATIONS

ALLERGIES: ______________________

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

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.

*** 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

BLOOD GAS & ACID-BASE REPORT
RESPIRATORY LAB

DATE:

WARD:

FULL NAME:

YEAR OF BIRTH:

HOSPITAL #:

PHYSICIAN:

PRINTED IN CANADA

ACID-BASE REPORT RESPIRATORY LAB

DIAGNOSIS:

[ ] ARTERIAL [ ] ROOM AIR
[ ] CAPILLARY [ ] OXYGEN ________ L/min.
[ ] SCALP ________ %
[ ] CORDS [ ] DEVICE ________
[ ] VENOUS

	PO_2 mmHg	
	PCO_2 mmHg	
	pH	
	HCO_3 mmol/L [ ] Std. [ ] Calc.	
	B.E. / B.D. mmol/L	
	O_2 SAT [ ] Meas'd [ ] Calc.	
	O_2 CONTENT g/L	
	HEMOGLOBIN (Hb g/dl)	
	CARBOXYHEMOGLOBIN (HbCO%)	
	METHEMOGLOBIN (MetHb%)	
	P5O	

SIGNATURE:

DATE:	TIME TAKEN
	TIME ANALYZED

BLOOD GAS & ACID-BASE REPORT
RESPIRATORY LAB

DATE:

WARD:

FULL NAME:

YEAR OF BIRTH:

HOSPITAL #:

PHYSICIAN:

PRINTED IN CANADA

ACID-BASE REPORT RESPIRATORY LAB

DIAGNOSIS:

[ ] ARTERIAL [ ] ROOM AIR
[ ] CAPILLARY [ ] OXYGEN ________ L/min.
[ ] SCALP ________ %
[ ] CORDS [ ] DEVICE ________
[ ] VENOUS

	PO_2 mmHg	
	PCO_2 mmHg	
	pH	
	HCO_3 mmol/L [ ] Std. [ ] Calc.	
	B.E. / B.D. mmol/L	
	O_2 SAT [ ] Meas'd [ ] Calc.	
	O_2 CONTENT g/L	
	HEMOGLOBIN (Hb g/dl)	
	CARBOXYHEMOGLOBIN (HbCO%)	
	METHEMOGLOBIN (MetHb%)	
	P5O	

SIGNATURE:

DATE:	TIME TAKEN
	TIME ANALYZED

*** 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/MMM/YYYY SEX: ☐ F ☐ M

FACILITY PATIENT ID NO.: ....

PHIN (9 DIGITS): ....

PHYSICIAN/PHYSICIAN NO.: ....

COLLECTION DATE: ....

COLLECTION TIME: ....

COLLECTED BY: ....

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

VOLUME: ________ mL

	URINE	
☐	Sodium	NAU
☐	Potassium	KU
☐	Creatinine	CRU
☐	Osmolality	OSU
☐	Albumin	UALB
☐	Calcium	* CAU
☐	Chloride	CLU
☐	Citrate	* CITU
☐	Cortisol	* CORU
☐	Creatinine Clearance Ht. ______ cm Wt. ______ kg	CRCL
☐	Homovanillic Acid	* HVA
☐	Hydroxyindole Acetic Acid	* HIAA
☐	Metanephrines	* MNPH
☐	Oxalate	* OXU
☐	Phosphate	POU
☐	Porphobilinogen	* PBG
☐	Porphyrins	* POR
☐	Pregnancy Test	PREG
☐	Protein, Total	TPU
☐	Urea	UU
☐	Uric Acid	UAU
☐	Urobilinogen	* UBGQ
☐	Vanillymandelic Acid	* VMA
☐		
☐	Urinalysis (Dipstick)	UR
☐	Urine Microscopic Review **Reason must be given** Reason:	RFM
☐		

	CSF	
☐	Cell Count & Differential	CSFH
☐	Chloride	CLC
☐	Glucose	GLC
☐	Protein, Total	PC
☐		

	FLUIDS	
☐	Type ________	
☐	Cell Count & Differential	HFLD
☐	Crystals	CRYS
☐	Fetal Lung Maturity	LP
☐	Fluid for Eosinophils	FFE
☐	Albumin	ALFL
☐	Bilirubin, Total	BFL
☐	Chloride	CLFL
☐	Creatinine	CRFL
☐	Glucose	GFL
☐	LD	LDFL
☐	Lipase	LPFL
☐	Potassium	KFL
☐	Protein, Total	TPFL
☐	Sodium	NAFL
☐	Urea	UFL
☐	Uric Acid	UAFL

	STOOL	
☐	Fat (Quantitative)	* FF
☐	Natural & Split Fats	FECA
☐	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

*** 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 HSC is an operating division of the Winnipeg Regional Health Authority

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 ________

Confidentiality Caution – This message is intended for the use of the individual or entity to which it is addressed and contains information that is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited.

CONTACT LIST

Fax and Contact Phone Numbers

	Fax #	Phone #
DI Access Centre (For First Available Appointment)	**787-8910**	787-8907
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

Blood Glucose Record

Insulin Titration Orders:

Date	Time	Blood Sugar		Insulin/Hypoglycemic	Initials	
		Blood Glucose Meter	Serum Glucose		Given by	Verified by

Guidelines for Use

Name of Form: Blood Glucose Record	
Special Instructions	**By Whom**
1. Addressograph	Unit Clerk
2. Transcribe Insulin Titration Orders.	Unit Clerk
3. Document date, time, blood sugar results.	Nurse
4. Document insulin infusion.	Nurse
5. Initial insulin infusion.	First nurse
6. Confirm insulin infusion.	Second nurse
7.	
8.	
9.	
10.	