

Cadham Provincial Laboratory
General Requisition



ONLY ONE SPECIMEN TYPE PER REQUISITION

All areas of the requisition must be completed (please **print** clearly)
 See back for requisition/specimen instructions

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

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

ADDRESSOGRAPH

RELEVANT CLINICAL INFORMATION		PATIENT INFORMATION	
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"/> Military # <input type="checkbox"/> Other _____	
<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		Date of Birth: YYYY/MM/DD	Sex: M F U A Chart/Clinic/Lab #
Signs and Symptoms:		Patient Legal Name: Last	
<input type="checkbox"/> Bronchiolitis <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		First Name	
Other: _____		Street or Other (e.g., General Delivery) Phone #	
Reason for Test:		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		RETURN REPORT TO:	
SPECIMEN INFORMATION		Ordering Practitioner Last Name First Initial(s)	
Specimen Type:	Specimen Source:	Facility	
Collected At: _____	Date/Time: YYYY/MM/DD HH/MM	Facility Address City/Town	
COPY REPORT TO:		Postal Code Phone # Secure Fax #	
Other Practitioner Last Name First Name			
Facility	Secure Fax #		

SEROLOGY	PARASITOLOGY
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"/> 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"/> Screen <input type="checkbox"/> HIV1/2Ab	MICROBIOLOGY/BACTERIOLOGY <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"/> Screen <input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> HBV PCR/Quant <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBsAb (Immunity) <input type="checkbox"/> HCV PCR/Qual <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	VIRUS DETECTION <input type="checkbox"/> Viral Studies <input type="checkbox"/> CMV PCR (NAAT) <input type="checkbox"/> HSV PCR (NAAT)
Miscellaneous Serology 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	OTHER TESTS OR REQUESTS

Name
PHIN

CPL Name
PHIN

CPL Specimen label stickers. Where necessary, please fill one in and affix to the accompanying specimen container.

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 (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 Reason for Test 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) (4):** 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 (5):** (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.