

	compl	<b>C/SL4 Facility Patient Label</b> of ete all fields to ensure accurate nt identification and registration	<ul> <li>✓ Promo</li> <li>✓ Reduct</li> <li>✓ Ensure</li> </ul>	<b>providing CLS wit</b> tes patient safety throus es turnaround time whos reports are sent to t appropriate) in a timely	ugh red Ien proc he corre	uced tran cessing pa ect facility	scription errors atient samples		
Patient	PHN	Information Required:	Alternate Identifier     Date of Birth (yyyy-mm-dd)					-mm-dd)	
	Last Na	<ul> <li>Name of Patient</li> <li>PHN</li> </ul>	First Name		Mide	If additional " <b>Copy To</b> " reports are required, provide full last name, first name and address for accurate report delivery			
G	Addres	<ul><li>Date of Birth</li><li>Gender</li></ul>	City/To	Apply <b>Pharmacy</b>	pv				
(s	Reques (last, first)	tor Name LTC/SL4 Care Centre	Copy to				Copy to (last, first) Example, Second CC Doctor		
Requestor (s)	Locatio	n/Facility/Address		Location/Facility/Address Pharmacy, "Specific Name" Expedite			Location/Facility/Address 30 Report Street NE		
anba	Phone	00000 Dr.	Phone (000000A)			Phone	XXXX		
Re	Health	care Provid <del>er ID</del>	Healthcare Pr	Healthcare Provider ID			Healthcare Provider ID 00XXXXC		
Co	llectior	Apply LTC/SL4 Facility Star	-	Location U	nit/roo	om #	Collector ID		
	(may have name of individual unit in address, when applicable). Add Ordering physician full last			LTC/SL4 Add Patient's Unit/Room Number for Blood Collections. Blood collection date, time					
		and first name.		and collector ID will be completed by Laboratory. All collection information should be completed by LTC/SL4 for non-blood specimens.					



## Requisition Requirements – Community Requisition for Long Term Care and Supportive Living

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Note: **Microbiology Orders** (i.e. urine and stool cultures) should be requested on a *REQ9021MI Microbiology Requisition* 

	Services Book online at	www.calgary	OMMENDED vlabservices.com			d at each visit or Scan	
$\square$	PHN		ernate Identifier			rth (yyyy-mm-dd)	1
Patient	Last Name	Fin	First Name M		Idle Gende	er Phone	-
Pati		1.0	95		<u> </u>	F	4
	Address	20.0	City/Town	Prov	Postal Code	e Location	
-	Requestor Name (last, first)		Copy to (last, first)		Copy to (last, first)		
sto	Location/Facility/Address	L	Location/Facility/Address		Location/Facilit	//Address	
	Phone	Р	Phone		Phone		
Red	Healthcare Provider ID	н	Healthcare Provider ID		Healthcare Provider ID		
Co	Ilection Date (yyyy-mm-dd)	Time	e (24 hr) Lo	cation	Collec	tor ID	
	Creatinine (Serum or Plass Electrolytes (NK, K) Lipid profile ####################################	ALB CLAP CLAP CLAP CLAP CLAP CLAP CLAP CLAP	Chioride Chioride Chioride Chioride Chioride Creacitive Protein Creacitive Protein Gradina Kinase Gamma Giutamyl Transferase Glucose - Rantognway neuwel Glucose - Rantognway Glucose - Rantogn (fast glucose - Rantogn (fast glucose) Glucose G	IMMGLOB         M           MONOT         IM           MONOT         IM           MONOT         IM           MONOT         IM           MONOT         IM           RUBG         IF           RUBG         IF           FSH         IF           HE         I           HE <t< th=""><th>HISEEROLOGY GG, IgA, IgM ionotest inductor GG, IgA, IgM ionotest inductor GG, Iono-Pregnant) DOCRINE Estradiol (Non-Pregnant) H H SH EHEPATITIS EHEPATITIS EHEPATITIS EHEPATITIS SUrder Hepatitis Soreen NIT-HAVI IgM MMUNE STATUS MMUNE STATUS INIT-Hepatitis B Surface Anibody STRY (URINE) required for all Creatinine Use Only End</th><th>TYPE ABO &amp; Rh Typing MISCELLANEOUS HIV HIV Serology ProvLab (Netical Reasons) HIVDSC HIV Serology CLS (Patient Patri Vias, Insurance, Immigration, Company Use) FIT Colorectal Camer Screening (Asymptomatic 59-74 years of ape)</th><th>Last dose information is required</th></t<>	HISEEROLOGY GG, IgA, IgM ionotest inductor GG, IgA, IgM ionotest inductor GG, Iono-Pregnant) DOCRINE Estradiol (Non-Pregnant) H H SH EHEPATITIS EHEPATITIS EHEPATITIS EHEPATITIS SUrder Hepatitis Soreen NIT-HAVI IgM MMUNE STATUS MMUNE STATUS INIT-Hepatitis B Surface Anibody STRY (URINE) required for all Creatinine Use Only End	TYPE ABO & Rh Typing MISCELLANEOUS HIV HIV Serology ProvLab (Netical Reasons) HIVDSC HIV Serology CLS (Patient Patri Vias, Insurance, Immigration, Company Use) FIT Colorectal Camer Screening (Asymptomatic 59-74 years of ape)	Last dose information is required
BHCG	<ul> <li>Beta HCG (Plasma or Se</li> </ul>		I Urea RINE DRUG SCREEN	Urine Volume	mL	OTHER TESTS NOT LISTED	
GEST GTTP SYP	Glucose Tolerance (75g (Fasting Required) Call 403-770-5136 to bo	<sup>g)</sup> UDSR 🗆 k FDSU 🗆	Drugs of Abuse Screen     (See CLS Website)     Drug Screen Comprehensive     Requires History Form DS3601     (See CLS Website)	UCAD 0 ( UCORD 0 ( U24H 0 ( CREACL 0 (	Albumin Creatinine Ratio Calcium Cortisol Creatinine Creatinine Clearance cm Weight kg		Patient medication information is
PVAS Collec MATS	:tion Date: Time::	DRSCMISC	(,	U24MALB /	Albumin (24 hr) Protein (24 hr) Protein Electrophoresis (24 hr)		required for Toxicology or Drug Scree
	ING HOURS (PC): # OF TUBES COLI 2001279C 201400892	ECTED:	TUBE TYPE:		ACCESSION NU	JMBER:	