



Requesting Facility / Clinic: <input type="checkbox"/> Printed copy of report not required.	*Patient Information required: LN, FN, Dob (dd/mm/yyyy), sex, pt phone number, HSN (specify Province) *Name: *Dob. (Day/month/year) *Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female *Sask HSN: (_____ 9 digits _____) Other Province HSN (_Prov_ # _____)	
Requesting Dr: Name / Initials) Clinic Address: RQHR Dr Code: _____ <input type="checkbox"/> Fax report to: () -	Patient Address: Patient Phone Number: Ward: Facility id (MRN)	
**Copy for: Dr; Clinic; address RQHR Dr Code: _____ <input type="checkbox"/> Fax report to: () -	**Copy for: : Dr; Clinic; address RQHR Dr Code: _____ <input type="checkbox"/> Fax report to: () -	**Copy for: : Dr; Clinic; address RQHR Dr Code: _____ <input type="checkbox"/> Fax report to: () -
Relevant DIAGNOSIS	Specimen Type (if not serum)	Date to be Collected : Time : <hr/> Collected by Date / Time
<input type="checkbox"/> CBC <input type="checkbox"/> PT/INR <input type="checkbox"/> APTT <input type="checkbox"/> Thrombin Time Indicate Anticoagulant (required) <input type="radio"/> Coumadin / Warfarin <input type="radio"/> Dabigatran (Pradax) <input type="radio"/> Heparin <input type="radio"/> Rivaroxaban (Xarelto) <input type="radio"/> Low Molecular Wt Heparin (Fondaparinux) <input type="radio"/> None Glucose <input type="checkbox"/> Fasting <input type="checkbox"/> Random <input type="checkbox"/> 2h pc <input type="checkbox"/> HbA1c <input type="checkbox"/> Maternal GTT (50gm 1h) (non-fasting) <input type="checkbox"/> Maternal GTT (75gm 2h) (fasting) <input type="checkbox"/> 75gm 2h (non-pregnant) (fasting) <input type="checkbox"/> Electrolytes <input type="checkbox"/> Renal (Lytes, Urea, Creatinine) <input type="checkbox"/> LIVER (TBil, ALT, ALP) <input type="checkbox"/> LIPID - FASTING (Chol, HDL, LDL, Trig) Individual Tests <input type="checkbox"/> Total Bilirubin <input type="checkbox"/> Calcium <input type="checkbox"/> Magnesium <input type="checkbox"/> Phosphorus <input type="checkbox"/> T. Protein <input type="checkbox"/> Albumin <input type="checkbox"/> Uric acid <input type="checkbox"/> Creatinine <input type="checkbox"/> Urea <input type="checkbox"/> Amylase <input type="checkbox"/> AST <input type="checkbox"/> CK <input type="checkbox"/> FSH / LH <input type="checkbox"/> Prolactin <input type="checkbox"/> Estradiol	<input type="checkbox"/> TSH Screen Thyroid Follow-up Tests <input type="checkbox"/> TSH <input type="checkbox"/> Free T4 <input type="checkbox"/> Fe / TIBC / %sat <input type="checkbox"/> Ferritin <input type="checkbox"/> Vitamin B12 <input type="checkbox"/> Folate <input type="checkbox"/> PSA <input type="checkbox"/> CEA <input type="checkbox"/> CA125 <input type="checkbox"/> B-HCG <input type="checkbox"/> AFP Therapeutic Drugs Last Dose (date/time) _____ <input type="radio"/> Random <input type="radio"/> Trough <input type="radio"/> Peak <input type="checkbox"/> Carbamazepine (Tegretol) <input type="checkbox"/> Cyclosporin <input type="checkbox"/> Digoxin <input type="checkbox"/> Gentamicin <input type="checkbox"/> Lithium <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Phenytoin (Dilantin) <input type="checkbox"/> Sirolimus <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Valproic Acid <input type="checkbox"/> Vancomycin Collect on Ice / Ship Frozen <input type="checkbox"/> Lactate <input type="checkbox"/> Ammonia <input type="checkbox"/> H. Pylori	Urine <input type="checkbox"/> Pregnancy Test <input type="checkbox"/> Urinalysis <input type="checkbox"/> Microalbumin / Creat ratio <input type="checkbox"/> Urine Microalbumin 24 Urine Volume: _____ ml Start date: _____ End Date: _____ <input type="checkbox"/> Total Protein Urine <input type="checkbox"/> 24h Urine Creatinine <input type="checkbox"/> Creatinine Clearance Patient Ht (cm): _____ Patient Wt (Kg): _____ Creatinine (within prev. 48h): _____ <input type="checkbox"/> Stool Occult Blood <input type="checkbox"/> Other:

***The labeling information on the specimens submitted must match the requisitions for the patient.**

Specimen containers must be labeled with the patient name (last and first), date of birth (day, month, year) and HSN.

**Copies for additional physicians, may not be sent if the mailing address cannot be determined. The RQHR Doctor code can be requested by calling (306) 766-3598

OTHER Testing - Refer to the RQHR Test Compendium for available testing and sample / shipping requirements.

http://www.rqhealth.ca/programs/lab/pdf_files/rqhr_lab_specimen_requirements.pdf