IMMUNOLOGY LABORATORY REQUISITION

[Autoimmune Testing available on R250-10-85]

Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection

Ordering Provider Information		
*Last & Full First Name:		Billing Code:
Inpatient Location:	Critical Results Ph #:	
*Facility Name/ Address		
Ph #:	Fax #:	
Copy Report To *(if info missing, report may not be sent)*:		
Last & Full First Name:	Ph #:	Fax #:
Facility Name/ Address:		
Last & Full First Name:	Ph #:	Fax #:
Facility Name/ Address:		

Patient Information *(print or use addressograph)*
*Last/First Name: (per Health Card)

* Date of Birth (dd/mm/yyyy)
*Sex: □ Female □ Male

*PHIN: Specify Province or DND if different
MRN:
Encounter #:
Patient Ph #:

Patient Address:

Demographics verified via:
❑ Health Card ❑ Armband ❑eChart/CR ❑Other

Collection Information (fields marked with ♦required by person collecting sample)		
♦ Collector:	♦ Collection Date:	♦Collected via: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line
♦ Collection Facility/Lab:	♦ Collection Time:	
# Serum vial(s) _____	# Plasma vials(p) _____	Referring Lab: # of tubes sent _____ Samples shipped frozen ❑

Clinical Information/Diagnosis:

Monoclonal Antibody Therapy: □ No □ Yes Generic Name: _____

Family History of Alpha-1-Antitrypsin Deficiency: □ No □ Yes

24 Hour Urine Collection: Start Date/Time: _____ Stop Date/Time:_____ Vol(ml):_____

LAB USE ONLY
PLACE BARCODE HERE

Nephelometry/Turbidimetry			
☐ **IGG**	Immunoglobulin IgG	☐ **C3**	Complement C3
☐ **IGA**	Immunoglobulin IgA	☐ **C4**	Complement C4
☐ **IGM**	Immunoglobulin IgM	☐ **RF**	Rheumatoid Factor
☐ **AATD**	Alpha-1-Antitrypsin	☐ **IGGS**	IgG Subclasses
☐ **CEI**	C1 Esterase Inhibitor	☐ **FLCH**	Serum Free Light Chains
☐ **A2M**	Alpha-2-Macroglobulin		
☐ **CH50**	Total Complement Activity	**Separate serum within one (1) hour of collection. Immediately freeze and store aliquot at -70°C. If sample cannot be frozen at -70°C and shipped on dry ice, freeze at -20°C and ship frozen.**	
Electrophoresis			
☐ **PE**	Serum Monoclonal Protein Investigation	**Includes IgG, IgA, IgM & FLCH**	
☐ **PEU**	24 Hour Urine Monoclonal Protein Investigation	**Random/Spot urine samples will be rejected**	
☐ **AATP**	Alpha-1-Antitrypsin Phenotyping	**Automatic reflex for patients with AATD <1.1g/L**	
Other			
☐ **VIS**	Serum Viscosity	**Minimum 20ml RED TOP, NO GEL clotted at 37°C**	
☐ **CRYO**	Cryoglobulin	**Minimum 15ml RED TOP, NO GEL clotted at 37°C**	
☐ **IGD**	Immunoglobulin IgD	**Pediatric patients or patients with IgD Monoclonal Protein**	
Referral			
☐ **MIS8**	Referral tests to all labs excluding MITOGEN	**See LIM entry for each test. Prior approval may be required. Complete the Immunology/Hematology Approval for Testing Form [F150-100-100]**	
☐ **MITO**	Referral tests to MITOGEN Diagnostics		

List tests:

Shared health Soins communs Manitoba

Immunology Laboratory, Health Sciences Centre
MS543L, 820 Sherbrook St
Winnipeg, MB R3A 1R9
Phone: 204-787-2156
Fax: 204-787-2058

Additional requisitions and sample requirements available at:
https://apps.sbgh.mb.ca/labmanual/

R250-10-21 V02
Approval Date: 09-OCT-2020