Saskatoon Health Region
COMMUNITY MOBILE PHLEBOTOMY REQUISITION

To be used for Saskatoon and Area Residents Only

Clinical Diagnosis: _____ PHN #: _____ Chart #: _____

Requesting Physician: _____ Name: _____ ❑ M ❑F
Last First

Date of Birth: _____ Phone #: _____
dd/mm/yy

Address: _____ Additional Copies of Report to: _____

Frequency: ❑ One time only ❑ Weekly ❑ Bi-weekly ❑ Every 4 weeks

IN ORDER TO QUALIFY FOR MOBILE SERVICE, YOUR PATIENT MUST MEET THIS CRITERION:
Client must be unable, either temporarily or permanently for reasons of a disability or poor health, to leave their home.

Please check the appropriate box:
❑ Post-Op ❑ Disability ❑ 2 – Man Transfer ❑ Bedridden ❑ Early Release from Hospital
❑ Other (must specify)

PHYSICIAN SIGNATURE: _____ **FAX COMPLETED REQUISITION TO 655-4021**
(Required to process request)

CBC	❑ CBC (&diff)
PT	❑ PT (INR)
APTT	❑ PTT (APTT)

ALP	❑ Alkaline Phosphatase
ALT	❑ Alanine Aminotransferase
AST	❑ Aspartate Aminotransferase
BILIT	❑ Bilirubin (total)
GGT	❑ Gamma Glutamyltransferase
LIP	❑ Lipase
CK	❑ CK Total
TP	❑ Protein - Total
ALB	❑ Albumin
CHOL	❑ Cholesterol
GLUCR	❑ Glucose - Random
HMA1C	❑ Hemoglobin A1C

UREA	❑ Urea
CREAT	❑ Creatinine
LYTE4	❑ Electrolytes (Na,K,Cl,CO2)
URIC	❑ Uric Acid
CA	❑ Calcium
PHOS	❑ Phosphate
MG	❑ Magnesium
FER	❑ Ferritin
OTHER	❑ _____ ❑ _____

CRCLE	❑ Est. Creatinine Clearance Wt: _____ KG

CARBZ	❑Carbamazepine (Tegretol)
PHENB	❑ Phenobarbital
DIGI	❑ Digoxin
LITH	❑ Lithium
	❑
PTNY	❑ Phenytoin (Dilantin)
VALPR	❑ Valproic Acid (Epival)

Dosage: _____
Date: _____
Time: _____

ALL INFORMATION MUST BE PROVIDED TO ENSURE PROCESSING IS NOT DELAYED