

PROGRAM Standard Operating Procedure	
Title: SCM12100 Completing Laboratory Requisitions	Policy Number: 15-11-V3
Program Name: Laboratory Services; EMR	
Applicable Domain: Lab, DI and Pharmacy Services	
Additional Domain(s): Hospital Based Clinical Services, Information Management and Privacy, Practitioner Staff	
Effective Date: 03/04/2025	Next Review Date: 03/04/2027
Issuing Authority: Director, Laboratory and Diagnostic Imaging Services	Date Approved: 03/04/2025
Accreditation Canada Applicable Standard: Biomedical Laboratory Services 11.0	
Accrediting Body and Standard: N/A	

### **GUIDING PRINCIPLES:**

Safe - Cultural safety and staff safety is aligned with avoiding harm to patients/clients from the care that is intended to help them.

Equitable - Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Efficient - Avoiding waste of resources (equipment, supplies, ideas, energy, time, and people)

### **PURPOSE/RATIONALE:**

This procedure provides instructions for ordering practitioners to correctly complete laboratory requisitions.

Correct and complete requests for laboratory service assist the laboratory in attributing laboratory results to the correct patient and provider.

By completing requisitions correctly and fully, laboratory results can be provided and delivered in a timely fashion to aid in patient care management and maintain the privacy of our client.

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## DEFINITIONS: N/A

## SCOPE/APPLICABILITY:

All ordering practitioners and support staff whom complete laboratory requisitions for patient testing.

## PROCEDURE:

- See Appendix A for Quick Reference Guide for Completing Laboratory Requisitions.
- See Appendix B for Quick Reference Guide for Completing the NTHSSA Laboratory Microbiology Requisition

### Patient Demographics

To ensure accurate identification of the patient so results will be attributed to the correct patient record it is imperative that the patient information fields be completed accurately and fully.

Patient	PHN / Healthcare Number <b>1</b> Expiry: _____		Alternate Identifier <b>2</b>	
	Legal Last Name <b>3</b>	Legal First Name <b>4</b>	Middle Name <b>5</b>	Date of Birth ( <i>dd-Mon-yyyy</i> ) <b>6</b>
	Preferred Name <b>7</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X (Non-Binary/Prefer not to Disclose) <b>8</b>		Phone <b>9</b>
	Address <b>10</b>	City / Town	Province	Postal Code

1. PHN / Healthcare number
  - a. Enter the two letter province code and the Personal Healthcare Number (PHN) to ensure accurate identification of the patient and billing of the service.
2. Alternate Identifier
  - a. If you are ordering the laboratory test from a hospital facility that utilizes chart numbers generated by the MediPatient system this number can be entered here to assist in correct patient identification. This number is also known as the Medical Record Number (MRN) and should be prefaced with the two digit location identification:
    - i. ST = Stanton
    - ii. IN = Inuvik
    - iii. HR = Hay River
    - iv. FS = Ft. Smith
  - b. This number assists in ensuring correct electronic transmission of laboratory results in the HealthNet Viewer (iEHR) when the PHN is incomplete or unavailable.

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- c. Locations that do not utilize MediPatient or MRNs should leave this field blank ex. Community Health Clinics, Community Health Centres, correction centres etc...
- 3. Legal Last Name
  - a. This information must match the legal name utilized in the Electronic Master Patient Index (EMPI).
  - b. This might be different from what is currently printed on a patient's healthcare card if they have recently changed their legal name.
- 4. Legal First Name
  - a. This information must match the legal name utilized in the Electronic Master Patient Index (EMPI).
  - b. This might be different from what is currently printed on a patient's healthcare card if they have recently changed their legal name.
- 5. Middle Name
- 6. Date of Birth
  - a. Following the date format outlined on the requisition.
  - b. This information must match the date of birth utilized in the Electronic Master Patient Index (EMPI).
  - c. If there are discrepancies the patient should be instructed to contact the NWT Vital Statistics Office to correct this information.
- 7. Preferred Name
  - a. For patients that have a non-legal preferred name it is helpful for the laboratory team to have this information. This assists the laboratory in providing client centred service for those individuals that do not use or do not wish to be called by their legal name.
- 8. Gender
  - a. Check the box indicating the gender of the patient
- 9. Phone
- 10. Address
  - a. Accurate, current phone and address information assists in ensuring that patient records are correct and up to date. If the laboratory is required to contact the patient directly this information is what is used to update the patient record.
  - b. This information is also required for reporting to the Office of the Chief Public Health Officer (OCPHO) as legislated in the NWT Public Health Act and Regulations.

Provider(s)

Provider(s)	Authorizing Provider Name ( <i>Last, First, Middle</i> ) <b>1</b>		
	Address <b>2</b>		
	Provider ID <b>3</b>	Submitter ID <b>4</b>	Phone <b>5</b>
	Clinic / Building Name <b>6</b>		

1. Authorized Provider Name
  - a. In this field identifies the ordering clinician ordering the test(s)
  - b. This individual will be the Most Responsible Provider (MRP) for the order and will be required to 'sign off' on the results.
  - c. Include both the last and first names of the ordering clinician. If only the last name is provided laboratory reports may be attributed to the incorrect clinician as more than one clinician can have the same last name.
2. Address
  - a. This information is used to mail hard copies of reports to ordering clinicians that are not receiving results by eDelivery or Fax.
3. Provider ID
  - a. This is a unique clinician specific number.
  - b. This number will be the same no matter what location the clinician is ordering lab work from.
  - c. Provider codes can be found on OurNTHSSA at [Provider Codes – Our NTHSSA](#).
4. Submitter ID
  - a. This is a location specific number.
  - b. This number will be used to ensure that laboratory results are directed to the correct location by the correct method for that location: eDelivery; Fax; Mail.
  - c. Location codes can be found on OurNTHSSA at [Location Codes – Our NTHSSA](#).
5. Phone
  - a. This information is used to communicate critical or clinically significant results with the ordering clinician or ordering location as required.
6. Clinic / Building Name
  - a. The Clinic / Building Name is used to search the Laboratory Information System for the ordering location and to ensure that the Submitter ID field is correct.
  - b. Providing this information allows for double checking that the correct ordering location is selected and results are transmitted as required.

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## Copy To

Copy To 1	Authorizing Provider Name ( <i>Last, First, Middle</i> ) <b>1</b>
	Address <b>2</b>
	Phone <b>3</b>
	Clinic / Building Name <b>4</b>

In the Alberta Precision Laboratories (APL) Laboratory Information System copies of laboratory reports can be directed to either a clinician identified by their unique provider ID or a location identified by the Address and Clinic / Building Name. Up to two clinicians or locations can be identified on the requisition to receive a copy of the laboratory results.

1. Authorized Provider Name
  - a. Include both the last and first names of the clinician. If only the last name is provided laboratory reports may be sent to the incorrect clinician as more than one clinician can have the same last name.
  - b. This clinician will not be identified as a responsible provider for these test results and will not be required to 'sign off' on the results.
2. Address
  - a. This information is used to mail hard copies of reports to ordering clinicians or locations that are not receiving results by eDelivery or Fax.
3. Phone
  - a. In this field the phone number may be used to follow up with the location or clinician for which a copy of the result has been indicated.
4. Clinic / Building Name
  - a. The Clinic / Building name is used to identify the location where results have been requested to be sent.

## Collection

Collection	Date (dd-Mon-yyyy) <b>1</b>	Time (24h) <b>2</b>	Location <b>3</b>	Collector ID <b>4</b>
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When a specimen is collected, the following information is mandatory.

1. Date
2. Time
3. Location
4. Collector ID
  - a. The initials or name of the person who collected the specimen.

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#### Priority

1. The turnaround times for NWT laboratories are shorter than those sent to APL due to transportation.
  - a. Routine
  - b. Urgent – Less than 4 hours
  - c. STAT – Less than 55 minutes

Critical results will be called according to the NTHSSA Critical Values policy. To request a call with results, in the white space on the requisition, write "Please call results to [Name] at [Phone Number]" with a marker, different coloured pen or highlighted.

#### PERFORMANCE MEASURES:

- Providers will complete requisitions correctly 100% of the time.
- Any deviations in proper completion of requisitions to be documented in RL6.

#### CROSS-REFERENCES: N/A

#### ATTACHMENTS:

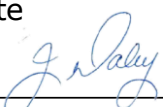
- Appendix A – SCM12101.2 Quick Reference Guide for Completing Laboratory Requisitions
- Appendix B – SCM12102.1 Quick Reference Guide for Completing the NTHSSA Laboratory Microbiology Requisition

#### REFERENCES:

- Laboratory Critical Results Procedure

#### APPROVAL:

April 03, 2025  
Date

  
Director, Laboratory and Diagnostic Imaging Services

#### REVISION HISTORY:

REVISION	DATE	Description of Change	REQUESTED BY
1.0	04 Jun 2020	Initial Release	J Daley
2.0	20 Dec 2020	Revision	J Daley, D Moore, L Schofield
2.1	13 Mar 2025	Periodic review; added in expected times for test priority; adjusted	C Russell

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		date format in revision table	

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## APPENDIX A

### Quick Reference Guide

### Completing the Laboratory Requisition – Patient Demographics

Use the two letter province  
code followed by the  
Healthcare Number

Enter the MRN if  
used at your facility

All patient demographics must  
match what is in the EMPI. If there  
is a discrepancy, ensure that the  
information is updated in the EMPI -  
"The Source of Truth"

Patient	PHN / Healthcare Number <b>NT N123 4567</b> Expiry: _____		Alternate Identifier <b>ST12345</b>	
	Legal Last Name <b>Legal Last Name</b>		Legal First Name <b>Legal First Name</b>	Middle Name <b>Middle Name</b>
	Preferred Name <b>Preferred Name</b> I		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X (Non-Binary/Prefer not to Disclose)	
	Address		City / Town	Province
			Date of Birth ( <i>dd-Mon-yyyy</i> ) <b>DD-Month-YYYY</b>	Phone <b>XXX-XXX-XXXX</b>
			Postal Code	

Preferred name is NOT a proper client identifier but,  
can assist the laboratory in providing patient centred  
care when the client presents for service: This will  
be the name we call out in the waiting room.

This field can be left blank if the client does not have  
a preferred name.

Accurate address and telephone  
information assists with ensuring  
accurate patient records. This  
information is also compiled for  
OCPHO as per the Public Health Act  
and Regulations



## Completing the Laboratory Requisition – Ordering Clinician and Copy To

This is the ordering clinician. Include the complete, legal first and last name of the ordering clinician.

Submitter ID is a unique assigned to each location a lab result is ordered from.

Provider(s)	Authorizing Provider Name (Last, First, Middle)			Copy To 1	Authorizing Provider Name (Last, First, Middle)
	Address Complete Address				Address
	Provider ID XXXXX	Submitter ID XXXXX	Phone XXX-XXX-XXXX		Phone
	Clinic / Building Name				Clinic / Building Name

Provider ID is the unique code assigned to each ordering clinician. This code is the same no matter which location you order lab tests from

Clinic / Building name is used to verify the location to which the final report will be sent

Copies of results can be requested to be sent to either another clinician or another location.

Copies requested to another clinician will be sent to that provider's default location only.

Copies requests to be sent to another location should include Address, phone and Clinic / Building name to ensure accurate delivery of results

## Completing the Laboratory Requisition – Collection and Priority

When a specimen is collected, the Collection information is mandatory.

The initials or name of the person who collected the specimen

<b>Collection</b>	Date (dd-Mon-yyyy)	Time (24h)	Location	Collector ID
<input type="checkbox"/> Routine <input type="checkbox"/> Stat	Requisition Date	Ⓡ Denotes a <b>Fasting Test</b> ⓘ Refer to Patient Instruction Sheet	Hours Fasting _____	<input type="checkbox"/> Third Party Bill? Client _____

Check the box with the appropriate Priority level

Critical results will be called according to the NTHSSA Critical Values policy.

To request a call with results, in the white space on the requisition, write

“Please call results to [Name] at [Phone Number]”

with a marker, different coloured pen or highlighted.

## APPENDIX B

### Quick Reference Guide

#### **Completing the NTHSSA Laboratory Microbiology Requisition – Choosing the Correct Requisition**

**For all microbiology testing performed at Stanton Territorial, ensure you are using the STH Microbiology Laboratory Microbiology Requisition**



**Microbiology Requisition**  
**Demande d'analyses microbiologiques**  
**Stanton Territorial Hospital Microbiology Laboratory**  
**1-867-767-9300 x 46691**

For Lab Use Only

## Completing the NTHSSA Laboratory Microbiology Requisition – Patient Demographics

<p><b>1</b> Provide the patient's Healthcare Number</p>	<p><b>2</b> Enter the MRN if used at your facility</p>	<p><b>3</b> All patient demographics must match what is in the EMPI. If there is a discrepancy, ensure that the information is updated in the EMPI</p>		
<p>PHN/Healthcare Number: <b>N1234567</b></p>		<p>Alternate Identifier: <b>ST12345</b></p>		
<p><b>4</b> Preferred name is NOT a proper client identifier. This field can be left blank if not applicable</p>	<p>Legal Last Name: <b>Legal Last Name</b></p>	<p>Legal First Name: <b>Legal First Name</b></p>	<p>Middle Name: <b>Middle Name</b></p>	<p>Date of Birth (YYYY-MM-DD) <b>YYY-Month-DD</b></p>
	<p>Preferred Name: <b>Preferred Name</b></p>	<p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/Prefer not to disclose</p>		<p>Phone: <b>XXX-XXX-XXXX</b></p>
	<p>Address:</p>	<p>City/Town:</p>	<p>Province:</p>	<p>Postal Code:</p>
<p><b>5</b> Accurate address and telephone information assists with ensure accurate patient records. This information is also compile for OCPHO as per the Public Health Act and Regulations</p>				

## Completing the NTHSSA Laboratory Microbiology Requisition – Ordering Clinician and Copy To

1  
This is the ordering clinician. Include the complete, legal first and last name

Provider(s)	Authorizing Provider Name (Last, First, Middle)	
	Address:	
	Phone:	
	Submitter ID:	Provider ID:
	Clinic / Building Name:	

2  
Submitter ID is a unique code assigned to each location a lab result is ordered from

3  
Provider ID is the unique code assigned to each ordering clinician. This code is the same no matter which location your order lab tests from

Copy to 1	Authorizing Provider Name (Last, First, Middle)	
	Address:	
	Phone:	
	Submitter ID:	Provider ID:
	Clinic / Building Name:	

4  
Clinic/Building name is used to verify the location to which the final report will be sent

Copy to 2	Authorizing Provider Name (Last, First, Middle)	
	Address:	
	Phone:	
	Submitter ID:	Provider ID:
	Clinic / Building Name:	

5  
Copies of results can be requested to be sent to either another clinician or another location  
  
Copies requested to another clinician will be sent to that provider's default location only  
  
Copies request to be sent to another location should include add, phone and clinic/building name to ensure accurate delivery of results

## Completing the NTHSSA Laboratory Microbiology Requisition – Test and Sample

**1** Indicate the sample Collection Date, Time, Location and Collector ID

**2** Indicate clinical symptoms of patient and reason for testing

**3** Indicate any antibiotics the patient is taking at the time of sample collection

**4** Indicate the test being requested

**5** Indicate the body site of the sample if applicable

**6** Indicate the source of the sample if applicable

Collection Date (YYYY-MM-DD)	Time (24 h)	Location	Collector ID	Outbreak Number
<b>BLOOD AND STERILE BODY FLUIDS</b>		PROVIDE RELEVANT CLINICAL SIGNS / SYMPTOMS / REASON FOR TESTING (If incomplete, testing may be cancelled)		
<input type="checkbox"/> Blood Culture	<input type="checkbox"/> Peripheral Venipuncture <input type="checkbox"/> Arterial Line <input type="checkbox"/> Central Line <input type="checkbox"/> Peripheral Line	<b>ANTIBIOTICS (Specify):</b>		
<input type="checkbox"/> Body Fluid Culture	<input type="checkbox"/> Pleural <input type="checkbox"/> Peritoneal <input type="checkbox"/> Synovial <input type="checkbox"/> Bursa			
<input type="checkbox"/> CSF Culture	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Lumbar Puncture <input type="checkbox"/> Shunt			
<b>WOUNDS/ABSCESS/SURGICAL SPECIMENS</b>		<b>EYES AND EARS</b>		
<input type="checkbox"/> Surface Wound Culture <2 cm (MUST SPECIFY SITE) Body Site: _____	<input type="checkbox"/> Cellulitis <input type="checkbox"/> Incision <input type="checkbox"/> Sore <input type="checkbox"/> Ulcer <input type="checkbox"/> Other: _____	<input type="checkbox"/> Ear Culture	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> External Ear <input type="checkbox"/> Middle Ear	
<input type="checkbox"/> Deep Wound Culture >2 cm (MUST SPECIFY SITE) Body Site: _____	<input type="checkbox"/> Drainage <input type="checkbox"/> Ulcer	<input type="checkbox"/> Eye Culture	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Superficial <input type="checkbox"/> Superficial <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Cornea	
<b>FOREIGN BODY</b>		<b>RESPIRATORY</b>		
<input type="checkbox"/> Catheter Tip Culture Body Site: _____		<input type="checkbox"/> Mouth/Tongue Culture (Oral Candidiasis)	<input type="checkbox"/> Penicillin Allergy	
<input type="checkbox"/> Urine Culture		<input type="checkbox"/> Nasal Culture (Staphylococcus aureus carriage)	<input type="checkbox"/> Treatment Failure	
<b>URINE</b>		<input type="checkbox"/> Sputum Expecterated		
<input type="checkbox"/> Midstream		<input type="checkbox"/> Endotracheal Suction (ETT)		
<input type="checkbox"/> Catheter-Indwelling		<input type="checkbox"/> Auger Suction		
<input type="checkbox"/> Catheter-Intermittent		<input type="checkbox"/> Bronchial Wash		
<input type="checkbox"/> Suprapubic/Cystoscopy		<input type="checkbox"/> Other: _____		
<b>ANTIBIOTIC RESISTANT ORGANISMS</b>		<input type="checkbox"/> Sputum MTB NAAT/PCR	<input type="checkbox"/> #1	<input type="checkbox"/> #2 <input type="checkbox"/> #3
<input type="checkbox"/> MRSA Screen	<input type="checkbox"/> Nares <input type="checkbox"/> Groin	<b>GENITAL TRACT</b>		
<input type="checkbox"/> VRE Screen	<input type="checkbox"/> Rectal <input type="checkbox"/> Stool	<input type="checkbox"/> Bacterial Vaginosis/Vaginitis Screen	<input type="checkbox"/> Vagina	<input type="checkbox"/> Urethra
<input type="checkbox"/> MRO Screen	Body Site: _____	<input type="checkbox"/> Trichomonas vaginalis Screen	<input type="checkbox"/> Vagina*	<input type="checkbox"/> Cervix
<b>GASTROINTESTINAL TRACT</b>		<input type="checkbox"/> Yeast Culture	<input type="checkbox"/> Penis	<input type="checkbox"/> Anus
<input type="checkbox"/> Clostridium difficile Toxin		<input type="checkbox"/> Gonorrhea Culture	<input type="checkbox"/> Cervix	<input type="checkbox"/> Urethra
<b>PRENATAL</b>		<input type="checkbox"/> Genital Culture*	<input type="checkbox"/> Throat	<input type="checkbox"/> Rectum
<input type="checkbox"/> Group B Screen (Vag. /Rectal) Screen	<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Eye	<input type="checkbox"/> Vagina	<input type="checkbox"/> Vulva
		<input type="checkbox"/> Labia	<input type="checkbox"/> Penis	<input type="checkbox"/> Cervix
			<input type="checkbox"/> Perianal	

\*CLINICAL HISTORY REQUIRED