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	UREA	❑ Urea	CRCLE	❑ Est. Creatinine Clearance Wt: _____ KG
ALT	❑ Alanine Aminotransferase	CREAT	❑ Creatinine		
AST	❑ Aspartate Aminotransferase	LYTE4	❑ Electrolytes (Na,K,Cl,CO2)		
BILIT	❑ Bilirubin (total)	URIC	❑ Uric Acid	CARBZ	❑Carbamazepine (Tegretol)
GGT	❑ Gamma Glutamyltransferase	CA	❑ Calcium		
LIP	❑ Lipase	PHOS	❑ Phosphate	PHENB	❑ Phenobarbital
CK	❑ CK Total	MG	❑ Magnesium	DIGI	❑ Digoxin
TP	❑ Protein - Total	FER	❑ Ferritin	LITH	❑ Lithium
ALB	❑ Albumin	OTHER	❑ _____		❑
CHOL	❑ Cholesterol		❑ _____	PTNY	❑ Phenytoin (Dilantin)
GLUCR	❑ Glucose - Random			VALPR	❑ Valproic Acid (Epival)
HMA1C	❑ Hemoglobin A1C			Dosage: _____	
				Date: _____	
				Time: _____	

ALL INFORMATION MUST BE PROVIDED TO ENSURE PROCESSING IS NOT DELAYED