

Filling out the Viral Gastrointestinal Disease Outbreak Requisition

Filling out the GI requisition

Once outbreak definition met, collect stool or vomitus samples and send to BCCDC lab

Monday to Friday, the CDEHO will email the outbreak identification # along with the MISYS #
Weekends and stats the ICP will email the outbreak identification # along with the MISYS #

- For each sample sent complete the [BCCDC Public Health Laboratory Gastrointestinal Disease Outbreak Requisition](#)
- indicate Viral / Bacterial Outbreak Test (do not use SAF vial) See below

Section 3 - Test Information

TEST REQUESTED	
<input checked="" type="checkbox"/> Viral / Bacterial Outbreak Test (do not use SAF vial) <input type="checkbox"/> Ova & Parasitic Test (use SAF vial) <input type="checkbox"/> Other, specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Diarrhea: <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdomina: <input type="checkbox"/> Fever <input type="checkbox"/> ...
SAMPLE TYPE	

- Include the VCH CDC MISYS # as ordering practitioner (see below)

BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Public Health Laboratory
 655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Gastrointestinal Disease Outbreak Requisition

LM LABS

Section 1 - Patient/Provider Information (Two matching unique patient identifiers on sample container and requisition are required for sample processing)

PERSONAL HEALTH NUMBER <small>(or out-of province Health Number and province)</small>		ORDERING PRACTITIONER <small>Name and MSC#</small> VCH CDC Contol MIYS # <small>Address of report delivery</small> (obtained from the CDEHO Mon-Fri or ICP weekends and stats)		<div style="border: 1px solid gray; padding: 5px; background-color: #f0f0f0;"> LABORATORY USE ONLY DATE RECEIVED OUTBREAK ID SAMPLE REF. NO. DATE COLLECTED (DD/MMM/YYYY) TIME COLLECTED (HH:MM) </div>
PATIENT SURNAME		<input type="checkbox"/> I do not require a copy of the report <input type="checkbox"/> I am a Locum ² <small>²If Locum, include name of Practitioner you are covering for</small>		
PATIENT FIRST AND MIDDLE NAME		ADDITIONAL COPIES TO PRACTITIONER / CLINIC: <small>(Name, Address / MSC# / PHSA Client#) (Limit of 3 copies available)</small>		
DOB <small>(DD/MMM/YYYY)</small>	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/> U (Unk)	1. 2. 3.		
PATIENT ADDRESS		CITY		
PROVINCE	POSTAL CODE			