

STANDARD OUT-PATIENT LABORATORY REQUISITION

ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER

Dr. Donald Duck
1234 Mickey Drive
Disneyland, Fairytale City
MSP # 11236

PLEASE USE ONE REQUISITION PER CLIENT

Yellow highlighted fields must be completed.

For tests indicated with a blue tick box , consult provincial guidelines and protocols (www.BCGuidelines.ca) https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

Bill to → MSP ICBC WorkSafeBC PATIENT OTHER: _____

PERSONAL HEALTH NUMBER: 8052 161 789 ICBC/WorkSafeBC NUMBER: _____ LOCUM FOR PRACTITIONER AND MSP PRACTITIONER NUMBER: _____

LAST NAME OF PATIENT: Lightyear FIRST NAME OF PATIENT: Buzz If this is a STAT order please provide contact telephone number: _____

DOB: 1981-01-02 SEX: M F Pregnant? YES NO Fasting? _____ h pc Copy to PRACTITIONER/MSP Practitioner Number: Copy to GP

PRIMARY CONTACT NUMBER OF PATIENT: _____ SECONDARY CONTACT NUMBER OF PATIENT: _____ OTHER CONTACT NUMBER OF PATIENT: _____ Copy to PRACTITIONER/MSP Practitioner Number: _____

ADDRESS OF PATIENT: 6789 1st Avenue CITY/TOWN: Vancouver PROVINCE: BC POSTAL CODE: V0N 1T6

DIAGNOSIS: _____ CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE: _____

HEMATOLOGY	URINE TESTS	CHEMISTRY
<input type="checkbox"/> Hematology profile <input type="checkbox"/> INR <input type="checkbox"/> Ferritin (query iron deficiency) HFE - Hemochromatosis (check ONE box only) <input type="checkbox"/> Confirm diagnosis (ferritin first, ± TS, ± DNA testing) <input type="checkbox"/> Sibling/parent is C282Y/C282Y homozygote (DNA testing)	<input type="checkbox"/> Macroscopic → microscopic if dipstick positive <input type="checkbox"/> Macroscopic → urine culture if pyuria or nitrite present <input type="checkbox"/> Macroscopic (dipstick) <input type="checkbox"/> Microscopic * * Clinical information for microscopic required: _____	<input type="checkbox"/> Glucose - fasting (see reverse for patient instructions) <input type="checkbox"/> Glucose - random <input type="checkbox"/> GTT - gestational diabetes screen (50 g load, 1 hour post-load) <input type="checkbox"/> GTT - gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour test) <input type="checkbox"/> GTT - non-gestational diabetes <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> Albumin/creatinine ratio (ACR) - Urine

MICROBIOLOGY - LABEL ALL SPECIMENS WITH PATIENT'S FIRST & LAST NAME, DOB, PHN & SITE

ROUTINE CULTURE On Antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____ <input type="checkbox"/> Throat <input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Superficial Wound, Site: _____ <input type="checkbox"/> Deep Wound, Site: _____ <input type="checkbox"/> Other: _____ VAGINITIS <input type="checkbox"/> Initial (smear for BV & yeast only) <input type="checkbox"/> Chronic/recurrent (smear, culture, trichomonas) <input type="checkbox"/> Trichomonas testing GROUP B STREP SCREEN (Pregnancy only) <input type="checkbox"/> Vagino-anorectal swab <input type="checkbox"/> Penicillin allergy CHLAMYDIA (CT) & GONORRHEA (GC) by NAAT Source/site: <input type="checkbox"/> Urethra <input type="checkbox"/> Cervix <input type="checkbox"/> Urine <input type="checkbox"/> Vagina <input type="checkbox"/> Throat <input type="checkbox"/> Rectum Other: _____ GONORRHEA (GC) CULTURE Source/site: <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Throat <input type="checkbox"/> Rectum Other: _____ STOOL SPECIMENS History of bloody stools? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> C.difficile testing <input type="checkbox"/> Stool culture <input type="checkbox"/> Stool ova & parasite exam <input type="checkbox"/> Stool ova & parasite (high risk, submit 2 samples) DERMATOPHYTES <input type="checkbox"/> Dermatophyte culture <input type="checkbox"/> KOH prep (direct exam) Specimen: <input type="checkbox"/> Skin <input type="checkbox"/> Nail <input type="checkbox"/> Hair Site: _____ MYCOLOGY <input type="checkbox"/> Yeast <input type="checkbox"/> Fungus Site: _____	HEPATITIS SEROLOGY <input checked="" type="checkbox"/> Acute viral hepatitis undefined etiology Hepatitis A (anti-HAV IgM) Hepatitis B (HBsAg ± anti-HBc) Hepatitis C (anti-HCV) <input checked="" type="checkbox"/> Chronic viral hepatitis undefined etiology Hepatitis B (HBsAg; anti-HBc; anti-HBs) Hepatitis C (anti-HCV) Investigation of hepatitis immune status <input type="checkbox"/> Hepatitis A (anti-HAV, total) <input type="checkbox"/> Hepatitis B (anti-HBs) Hepatitis marker(s) <input type="checkbox"/> HBsAg (For other hepatitis markers, please order specific test(s) below) <input type="checkbox"/> HIV Serology (patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting) <input type="checkbox"/> Non-nominal reporting	LIPIDS <input checked="" type="checkbox"/> one box only Note: Fasting is not required for any of the panels but clinician may specifically instruct patient to fast for 10 hours in select circumstances [e.g. history of triglycerides > 4.5 mmol/L, independent of laboratory requirements]. <input type="checkbox"/> Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia) <input type="checkbox"/> Follow-up Lipid Profile - Total, HDL & non-HDL cholesterol only <input type="checkbox"/> Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated) THYROID FUNCTION For other thyroid investigations, please order specific tests below and provide diagnosis. <input type="checkbox"/> Monitor thyroid replacement therapy (TSH Only) <input type="checkbox"/> Suspected Hypothyroidism (TSH first, FT4 if indicated) <input type="checkbox"/> Suspected Hyperthyroidism (TSH first, FT4 & FT3 if indicated) OTHER CHEMISTRY TESTS <input type="checkbox"/> Sodium <input type="checkbox"/> Creatinine / eGFR <input type="checkbox"/> Potassium <input type="checkbox"/> Calcium <input type="checkbox"/> Albumin <input type="checkbox"/> Creatine kinase (CK) <input type="checkbox"/> Alk phos <input type="checkbox"/> PSA - Known or suspected prostate cancer (MSP billable) <input type="checkbox"/> ALT <input type="checkbox"/> B12 <input type="checkbox"/> PSA screening (self-pay) <input type="checkbox"/> B12 <input type="checkbox"/> Bilirubin <input type="checkbox"/> Pregnancy test <input type="checkbox"/> GGT <input type="checkbox"/> T. Protein <input type="checkbox"/> β-HCG - quantitative
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OTHER TESTS - Standing Orders include expiry & frequency

- ECG
- FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program
- FIT No copy to Colon Screening Program

For Gastrointestinal Samples write: "Infectious Diarrhea Panel NAT" and specimen type (e.g. Emesis or Stool)
 For Respiratory Samples write: "Influenza/COVID Testing" and specimen type (e.g. Nasopharyngeal)

SIGNATURE OF PRACTITIONER: _____ DATE SIGNED: _____

DATE OF COLLECTION: _____ TIME OF COLLECTION: _____ COLLECTOR: _____ TELEPHONE REQUISITION RECEIVED BY: (employee/date/time)

INSTRUCTIONS TO PATIENTS (See reverse)
Other Instructions: