

# STANDARD OUT-PATIENT LABORATORY REQUISITION

ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER

**Yellow highlighted fields must be completed.**

For tests indicated with a blue tick box , consult provincial guidelines and protocols ([www.BCGuidelines.ca](http://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            |   | ICBC/WorkSafeBC NUMBER   | LOCUM FOR PRACTITIONER AND MSP PRACTITIONER NUMBER:              |             |
| LAST NAME OF PATIENT              |   | FIRST NAME OF PATIENT  | If this is a STAT order please provide contact telephone number: |             |
| DOB YYYY MM DD                    | SEX <input type="checkbox"/> M <input type="checkbox"/> F | Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO | Fasting? _____ h pc  |             |
| PRIMARY CONTACT NUMBER OF PATIENT |   | SECONDARY CONTACT NUMBER OF PATIENT                                | OTHER CONTACT NUMBER OF PATIENT                                  |             |
| ADDRESS OF PATIENT                |   | CITY/TOWN  | PROVINCE   | POSTAL CODE |

DIAGNOSIS \_\_\_\_\_ CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE \_\_\_\_\_

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

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

|   |   |   |
|---|---|---|
| <b>ROUTINE CULTURE</b><br>On Antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____<br><input type="checkbox"/> Throat <input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> Urine<br><input type="checkbox"/> Superficial Wound, Site: _____<br><input type="checkbox"/> Deep Wound, Site: _____<br><input type="checkbox"/> Other: _____<br><b>VAGINITIS</b><br><input type="checkbox"/> Initial (smear for BV & yeast only)<br><input type="checkbox"/> Chronic/recurrent (smear, culture, trichomonas)<br><input type="checkbox"/> Trichomonas testing<br><b>GROUP B STREP SCREEN</b> (Pregnancy only)<br><input type="checkbox"/> Vagino-anorectal swab <input type="checkbox"/> Penicillin allergy<br><b>CHLAMYDIA (CT) &amp; GONORRHEA (GC) by NAAT</b><br>Source/site: <input type="checkbox"/> Urethra <input type="checkbox"/> Cervix <input type="checkbox"/> Urine<br><input type="checkbox"/> Vagina <input type="checkbox"/> Throat <input type="checkbox"/> Rectum<br>Other: _____<br><b>GONORRHEA (GC) CULTURE</b><br>Source/site: <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Throat <input type="checkbox"/> Rectum<br>Other: _____<br><b>STOOL SPECIMENS</b><br>History of bloody stools? <input checked="" type="checkbox"/> Yes<br><input checked="" type="checkbox"/> C.difficile testing <input checked="" type="checkbox"/> Stool culture <input checked="" type="checkbox"/> Stool ova & parasite exam<br><input checked="" type="checkbox"/> Stool ova & parasite (high risk, submit 2 samples) | <b>HEPATITIS SEROLOGY</b><br><input checked="" type="checkbox"/> <b>Acute viral hepatitis undefined etiology</b><br>Hepatitis A (anti-HAV IgM)<br>Hepatitis B (HBsAg ± anti-HBc)<br>Hepatitis C (anti-HCV)<br><input checked="" type="checkbox"/> <b>Chronic viral hepatitis undefined etiology</b><br>Hepatitis B (HBsAg; anti-HBc; anti-HBs)<br>Hepatitis C (anti-HCV)<br><b>Investigation of hepatitis immune status</b><br><input checked="" type="checkbox"/> Hepatitis A (anti-HAV, total)<br><input checked="" type="checkbox"/> Hepatitis B (anti-HBs)<br><b>Hepatitis marker(s)</b><br><input checked="" type="checkbox"/> HBsAg<br>(For other hepatitis markers, please order specific test(s) below)<br><input type="checkbox"/> <b>HIV Serology</b><br>(patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting)<br><input type="checkbox"/> Non-nominal reporting | <b>LIPIDS</b><br><input checked="" type="checkbox"/> one box only<br>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].<br><input checked="" type="checkbox"/> Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia)<br><input checked="" type="checkbox"/> Follow-up Lipid Profile - Total, HDL & non-HDL cholesterol only<br><input checked="" type="checkbox"/> Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated) |
| <b>DERMATOPHYTES</b><br><input type="checkbox"/> Dermatophyte culture <input type="checkbox"/> KOH prep (direct exam)<br>Specimen: <input type="checkbox"/> Skin <input type="checkbox"/> Nail <input type="checkbox"/> Hair<br>Site: _____<br><b>MYCOLOGY</b><br><input type="checkbox"/> Yeast <input type="checkbox"/> Fungus Site: _____  | <b>OTHER TESTS - Standing Orders include expiry &amp; frequency</b><br><input type="checkbox"/> ECG<br><input type="checkbox"/> FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program<br><input type="checkbox"/> FIT No copy to Colon Screening Program   | <b>THYROID FUNCTION</b><br>For other thyroid investigations, please order specific tests below and provide diagnosis.<br><input checked="" type="checkbox"/> Monitor thyroid replacement therapy (TSH Only)<br><input checked="" type="checkbox"/> Suspected Hypothyroidism (TSH first, FT4 if indicated)<br><input checked="" type="checkbox"/> Suspected Hyperthyroidism (TSH first, FT4 & FT3 if indicated)  |
|   |   | <b>OTHER CHEMISTRY TESTS</b><br><input type="checkbox"/> Sodium <input type="checkbox"/> Creatinine / eGFR<br><input type="checkbox"/> Potassium <input type="checkbox"/> Calcium<br><input type="checkbox"/> Albumin <input type="checkbox"/> Creatine kinase (CK)<br><input type="checkbox"/> Alk phos <input type="checkbox"/> PSA - Known or suspected prostate cancer (MSP billable)<br><input type="checkbox"/> ALT <input type="checkbox"/> B12 <input type="checkbox"/> PSA screening (self-pay)<br><input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Pregnancy test<br><input type="checkbox"/> T. Protein <input type="checkbox"/> β-HCG - quantitative                    |

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:

The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.