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BC Centre for Disease Control
Provincial Health Services Authority

Public Health Laboratory

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

Virology Requisition

Highlighted fields must be completed

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

PERSONAL HEALTH NUMBER (or out-of-province Health Number)

PATIENT LAST NAME

PATIENT FIRST AND MIDDLE NAME

DOB DD MMM YYYY

SEX M ☐ F ☐ X ☐ Unk ☐

PATIENT ADDRESS

CITY

PROVINCE

POSTAL CODE

CONTACT NO. (XXX) XXX-XXXX

DATE RECEIVED

LABORATORY USE ONLY

SAMPLE REF. NO.

DATE COLLECTED (DD/MMM/YYYY) Unk ☐

TIME COLLECTED (HH:MM) Unk ☐

ORDERING PRACTITIONER (Name, MSP#, Address of report delivery)

☐ **I am a Locum** (provide name of Practitioner and Clinic to receive report)

ADDITIONAL COPIES TO PRACTITIONER / CLINIC: **(Limit of 3 copies available)**
(Name, Address / MSP#/ PHSA Client#)

1.

2.

3.

SIGNATURE OF ORDERING PRACTITIONER

DATE SIGNED

Section 2 - Test(s) Requested

For other available tests and additional information, consult the Public Health Laboratory's eLab Handbook at www.elabhandbook.info/PHSA/Default.aspx

RESPIRATORY

Indicate sample site:

☐ Nasopharynx ☐ Nares
☐ Oropharynx ☐ Throat
☐ Lower Respiratory Tract: _____
☐ Other, specify: _____

Indicate container type:

☐ Swab with transport medium
☐ Saline gargle
☐ Other, specify: _____

Indicate test(s):

☐ COVID-19 (SARS-CoV-2)
☐ Influenza A, Influenza B, Respiratory syncytial virus
☐ Avian influenza (e.g. H5)
(*Approval and exposure location required)
☐ Enterovirus D68
(Approval required outside August to October)
☐ Other test, specify: _____

HEPATITIS

Please see the ***Serology Screening Requisition*** to order HCV RNA and/or HCV genotyping testing

REFERRAL LABORATORY USE ONLY VIRAL TYPING BY NAT/SEQUENCING

Virus: _____

Sample site: _____

Ct value: _____ OR viral signal: weak / strong

Additional information: _____

SKIN / MUCOSAL

Indicate anatomical site: _____

Select one

☐ Skin Lesion ☐ Mucosal Lesion ☐ Mucosal Non-Lesion

Indicate test(s):

☐ Herpes simplex 1 (HSV 1) / Herpes simplex 2 (HSV 2) / Varicella zoster (VZV)
☐ Mpox
☐ Molluscum contagiosum
☐ Other test, specify: _____

ENCEPHALITIS

Cerebrospinal Fluid for:

☐ HSV 1, HSV 2, VZV and Enterovirus
☐ West Nile virus (Approval required outside July to September)
☐ Creutzfeldt-Jakob disease
☐ Other test, specify: _____

(**Note:** Send CSF from <6 months old directly to BC Children's & Women's Hospital Laboratory for testing that includes parechovirus)

MEASLES, MUMPS, RUBELLA

☐ Recent MMR vaccination ☐ Recent travel (*Provide travel history)

*RELEVANT EXPOSURE / TRAVEL OR OTHER HISTORY

(Please provide clinical history where indicated)

_____

_____

OUTBREAK LOCATION / INFORMATION

_____

_____

GASTROINTESTINAL

Feces for:

☐ Gastrointestinal Viral Panel
(Norovirus, Adenovirus, Astrovirus, Rotavirus, Sapovirus)
☐ Enterovirus
☐ Other test, specify: _____

OTHER TESTS

☐ Eye sample for Adenovirus, HSV 1, HSV 2, VZV
☐ Skin sample for Enterovirus
☐ Plasma for West Nile virus
☐ Other test, specify: _____

MEASLES

☐ Nasal / Nasopharyngeal swab
☐ Throat swab
☐ Urine
☐ Other sample type, specify: _____

MUMPS

☐ Buccal / Oral swab
☐ Urine
☐ Other sample type, specify: _____

RUBELLA

☐ Nasopharyngeal washing / swab
☐ Throat swab
☐ Urine
☐ Other sample type, specify: _____

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.