LifeLabs®
Medical Laboratory Services

Laboratory Requisition

This requisition form, when completed, constitutes a referral to LifeLabs laboratory physicians.

THIS AREA IS FOR LAB USE

COMPLETE and ACCURATE information is required in all shaded areas.

Patient Surname (from CareCard) | First | Initial(s) | Date of Birth (DAY / MONTH / YEAR) | Sex ☐ F ☐ M

Bill to: ☐ MSP ☐ ICBC ☐ WorkSafeBC ☐ Patient ☐ Other _____ | Chart Number | Room # (LTC use only)

PHN _____ I.D. Number _____

Patient Address | City, Province | Postal Code | Phone Number

Physician Name & MSC Number | Locum for: Physician _____ MSC # _____ | C0 Number | Date/Time of Collection | Phlebotomist | Date/Time/Name of Medication

Copy to | Pregnant ☐ Yes ☐ No | ☐ Fasting ____ hours prior to test | ☐ Phone ☐ Fax | Telephone Requisition Received By: INITIAL/DATE

Diagnosis and indications for guideline protocol and special tests

For tests indicated with a shaded tick box ☐, consult provincial guidelines and protocols (www.BCGuidelines.ca)

HEMATOLOGY

- ☒ Hematology profile
- ☒ PT-INR ☐ On Warfarin?
- ☐ Ferritin (query iron deficiency)
- ☐ Iron & transferrin saturation (Hemochromatosis screen)

} ☐ Special case (if ordered together)

CHEMISTRY

- ☐ Glucose - fasting (see reverse for patient instructions)
- ☐ Glucose _____ hours post meal
- ☐ GTT - gestational diabetes screen (50 g load, 1 hour post-load)
- ☐ GTT - gestational diabetes confirmation (75 g load, fasting, 1 & 2 hour test)
- ☐ GTT - non-pregnant (75 g load, 2 hour test)
- ☐ Hemoglobin A1c
- ☒ Albumin/creatinine ratio (ACR) - Urine

LIPIDS

✓ **One box only. For other lipid investigations, please order under Other Tests section and provide diagnosis.**

- ☐ Baseline cardiovascular risk assessment or follow-up (Lipid profile, Total, HDL & LDL Cholesterol, Triglycerides, fasting)
- ☐ Follow-up of treated hypercholesterolemia (**ApoB only**, fasting not required)
- ☐ Self-pay lipid profile (non-MSP billable, fasting)

THYROID FUNCTION

✓ **One box only. For other thyroid investigations, please order under Other Tests section and provide diagnosis.**

- ☐ Suspected Hypothyroidism TSH first (plus FT4 if required)
- ☐ Suspected Hyperthyroidism, TSH first (plus FT4 or FT3 if required)
- ☐ Monitor thyroid replacement therapy (TSH Only)

OTHER CHEMISTRY TESTS

- ☒ Sodium
- ☒ Potassium
- ☒ Albumin
- ☒ Alk phos
- ☒ ALT
- ☒ Bilirubin
- ☒ GGT
- ☐ T. Protein
- ☒ Creatinine/eGFR
- ☐ Calcium
- ☐ Creatine kinase (CK)
- ☐ PSA -MSP billable
- ☐ PSA screening (self-pay)

The personal information on this form and any medical data subsequently developed will be collected and used in compliance with the Personal Information Protection Act of British Columbia to provide medical services. Our privacy policy is available at www.lifelabs.com. Use of this form implies consent for the use of de-identified patient data and specimens for quality assurance purposes.

MICROBIOLOGY

LABEL ALL SPECIMENS WITH PATIENT'S FIRST AND LAST NAME, DOB AND/OR PHN & SITE

ROUTINE CULTURE

List current antibiotics: _____

- ☐ Throat ☐ Sputum ☐ Blood
- ☐ Superficial Wound Site: _____
- ☐ Deep Wound Site: _____
- ☐ Other: _____

VAGINITIS

- ☐ Initial (smear for BV & yeast only)
- ☐ Chronic/recurrent (smear, culture, trichomonas)
- ☐ Trichomonas testing

GROUP B STREP SCREEN (Pregnancy only)

- ☐ Vagino-anorectal swab ☐ Penicillin allergy

CHLAMYDIA (CT) & GONORRHEA (GC)

- ☒ CT & GC Testing
- ☐ Source/site: ☐ Urethra ☐ Cervix ☐ Urine
  GC culture: ☐ Throat ☐ Rectal
  ☐ Other: _____

STOOL SPECIMENS

History of bloody stools? ☐ Yes

- ☐ C. difficile testing
- ☐ Stool culture
- ☐ Stool ova & parasite exam
- ☐ Stool ova & parasite (high risk, 2 samples)

DERMATOPHYTES

- ☐ Dermatophyte culture ☐ KOH prep (direct exam)
  Specimen: ☐ Skin ☐ Nail ☐ Hair
  Site: _____

MYCOLOGY

- ☐ Yeast ☐ Fungus Site: _____

URINE TESTS

- ☐ Urine culture - list current antibiotics: _____
- ☒ Macroscopic → microscopic if dipstick positive
- ☐ Macroscopic → urine culture if pyuria or nitrite present
- ☐ Macroscopic (dipstick) ☐ Microscopic
  ☐ Special case (if ordered together)
- ☐ Pregnancy test

HEPATITIS SEROLOGY

✓ **One box only. For other Hepatitis Markers, please order under Other Tests section.**

- ☒ **Acute viral hepatitis undefined etiology**
  Hepatitis A (anti-HAV IgM)
  Hepatitis B (HBsAg, anti-HBs)
  Hepatitis C (anti-HCV)
- ☒ **Chronic viral hepatitis undefined etiology**
  Hepatitis B (HBsAg, anti-HBc, anti-HBs)
  Hepatitis C (anti-HCV)

Investigation of hepatitis immune status

- ☐ Hepatitis A (anti-HAV, total)
- ☐ Hepatitis B (anti-HBs)
- ☐ **Hepatitis marker(s)** HBsAg

HIV SEROLOGY

(patient has legal right to choose nominal or non-nominal reporting)

☒ Nominal reporting ☐ Non-nominal reporting

OTHER TESTS

☐ ECG ☐ Fecal Occult Blood

HIV plasma viral load
CD4/CD8 cell counts and percentage
HLA B5701 (CfE HIV/AIDS requisition included)
HIV Genotype (CfE HIV/AIDS requisition included)
Syphilis RPR
Hepatitis C qualitative PCR
Toxoplasma IgG

AST	CI
LDH	HCO3
Amylase	BUN

Standing Order requests - expiry and frequency must be indicated

Date | Physician Signature

BC Centre for Excellence in HIV/AIDS
St. Paul's Hospital
604-1081 Burrard St.
Vancouver, BC V6Z 1Y6
Tel. 604 806-8775 FAX 604 806-9463

BC Genotype FAX Requisition - HIV Drug Resistance Testing

TO: BC Centre for Excellence in HIV/AIDS, St. Paul's Hospital
FAX 604 806 9463

FROM: Physician _____

Address _____

_____

Telephone _____

FAX _____

REQUESTING PHYSICIAN: _____
SIGNATURE

*At least **two (2)** of the following patient identifiers are required:*

CFE Patient ID:

Patient Name:
Last First

Patient DOB:
Day Month Year

Sample Date(s)	*CfE Staff Use Only*	
dd / mm / yyyy	Virology Patient ID	CfE Patient ID

CfE Staff Use Only

Received By: Date Received:

BC Centre for Excellence
St. Paul's Hospital
604-1081 Burrard Street
Vancouver, BC V6Z 1Y6
Tel: 604-806-8645 Fax: 604-806-9463

For CfE Use Only
(CfE Patient Identifier)

HLA-B*5701 Laboratory Requisition - For Abacavir Hypersensitivity

*At least **two (2)** patient identifiers are required:*

CFE Patient ID:

Patient Name:
Last First

Patient DOB:
Day Month Year

Comment: (Not Required)

NOTE: Do NOT ship to Vancouver General Hospital (VGH) Laboratory

Send Blood To:
Dr. Richard Harrigan
BC Centre for Excellence in HIV/AIDS
Rm 604 - 1081 Burrard St., St. Paul's Hosp.
Vancouver, BC V6Z 1Y6
Tel: 604-806-8281, Fax: 604-806-9463

Requesting Physician: _____

_____

_____

_____

Signature: _____

CC:

Specimen Collection / Processing Instructions

Collection & Storage

> Collect whole blood in a **3 mL EDTA** (lavender top) tube. **Do NOT spin.**

> Label the tube of **whole blood** and the requisition with patient name, DOB and collection date.

> **Refrigerate (4°C) until ready to ship.**

Shipping

> **Ship specimens refrigerated (frozen ice packs)**.

> Do **not** ship specimens on Friday or Saturday.

> From **outside Vancouver**, notify lab by **faxing a copy** of the waybill, 604-806-9463.

Phlebotomist use only

Sample collected by: Date Collected:

CfE Lab Staff use only

Received By: Date Received: