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 _____

PHN _____ I.D. Number _____

Chart Number | Room # (LTC use only)

Patient Address | City, Province | Postal Code

Patient Telephone Number

Ordering Physician, Address, MSP Practitioner 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)

HFE – Hemochromatosis (check ONE box only)

- ☐ Confirm diagnosis (ferritin first, ± TS, ± DNA testing)
- ☐ Sibling/parent is C282Y/C282Y homozygote (DNA testing)

CHEMISTRY

- ☐ Glucose - fasting (see reverse for patient instructions)
- ☐ GTT - gestational diabetes screen (50 g load, 1 hour post-load)
- ☐ GTT - gestational diabetes confirmation (75 g load, fasting, 1 & 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, non-HDL & LDL Cholesterol, Triglycerides, fasting)
- ☐ Follow-up of treated hypercholesterolemia (Total, HDL & non-HDL Cholesterol, fasting not required)
- ☐ 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.
- ☐ Monitor thyroid replacement therapy (TSH Only)
- ☐ Suspected Hypothyroidism TSH first (plus FT4 if required)
- ☐ Suspected Hyperthyroidism, TSH first (plus FT4 or FT3 if required)

OTHER CHEMISTRY TESTS

- ☐ Sodium
- ☐ Potassium
- ☑ Albumin
- ☑ Alk phos
- ☑ ALT
- ☑ Bilirubin
- ☑ GGT
- ☐ T. Protein
- ☑ Creatinine/eGFR
- ☐ Calcium
- ☐ Creatine kinase (CK)
- ☐ PSA - Known or suspected prostate cancer (MSP billable)
- ☐ PSA screening (self-pay)
- ☐ Pregnancy Test ☐ Serum ☐ Urine

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)

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, plus anti-HBc if required)
  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

- ☑ HIV Serology
  (patient has legal right to choose not to have their name and address reported to public health – non-nominal reporting)
- ☐ Non-nominal reporting

OTHER TESTS

- ☐ ECG
- ☐ Fecal Occult Blood (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program.
- ☐ Fecal Occult Blood (other indications)

HIV plasma viral load
CD4/CD8 cell count
Syphilis serology
Hep C RNA
Toxoplasma IgG
AST, LDH, Amylase, BUN

Standing Order requests - expiry and frequency must be indicated

Date

Requisition is valid for one year from the date of issue.

Physician Signature

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:

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: