

For tests with a shaded box <input checked="" type="checkbox"/> consult provincial guidelines and protocols (www.BCGuidelines.ca) https://www2.gov.ca/gov/content/health/practitioner-professional-resources/bc-guidelines.		Ordering practitioner: address, phone, MSP number	
Bill to: <input type="checkbox"/> ICBC <input type="checkbox"/> MSP <input type="checkbox"/> WorkSafeBC <input type="checkbox"/> Patient <input type="checkbox"/> Other:			
Personal health number	ICBC/WorkSafeBC number		
Last Name of Patient		First Name of Patient	
		Locum for practitioner and MSP practitioner number:	
		If this is a STAT order please provide contact telephone number:	
DOB YYYY MM DD	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	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	Copy to practitioner/MSP practitioner number:
Address of Patient		City/Town	Province Postal Code
Diagnosis		Current medications/date and time of last dose	

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 health care 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 in the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.

Hematology	Urine Tests	Chemistry
<input type="checkbox"/> Hematology profile <input type="checkbox"/> INR <input type="checkbox"/> Ferritin (query iron deficiency) HFE - Hemochromatosis (ONE box only) <input checked="" type="checkbox"/> Confirm diagnosis (ferritin first, ±TS, ±DNA testing) <input type="checkbox"/> Sibling/parent C282Y/C282Y homozygote (DNA testing)	<input type="checkbox"/> On anticoagulant? <input type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____ <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 info 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 (50g load/1 hour post-load) <input type="checkbox"/> GTT-gestational diabetes confirmation (75g load/fasting/1+2 hr tests) <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 Name, DOB, PHN and Facility		
Routine Culture On antibiotics? <input type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____ <input type="checkbox"/> Throat <input type="checkbox"/> Sputum <input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Superficial wound (site): _____ <input type="checkbox"/> Deep wound (site): _____ <input type="checkbox"/> Other: _____ Vaginitis <input type="checkbox"/> Initial (smear for BV and 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 <input type="checkbox"/> Other: _____ Gonorrhea (GC) Culture Source/Site: <input type="checkbox"/> Urethra <input type="checkbox"/> Cervix <input type="checkbox"/> Throat <input type="checkbox"/> Rectum <input type="checkbox"/> 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 and parasite exam <input type="checkbox"/> Stool ova and parasite (high risk, 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 C (anti-HCV) Hepatitis B (HBsAg + anti-HBc) <input checked="" type="checkbox"/> Chronic viral hepatitis undefined etiology Hepatitis B (HBsAg + anti-HBc) Hepatitis C (anti-HCV) Investigation of hepatitis immune status <input type="checkbox"/> Hepatitis A (anti-HAV, total) <input type="checkbox"/> Hepatitis B (HBsAg + anti-HBc) Hepatitis marker(s) <input type="checkbox"/> HBsAg (For other hepatitis markers, please order specific test(s) below) <input checked="" 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 greater than 4.5 mmol/L], independent of laboratory requirements. <input type="checkbox"/> Full lipid profile - Total cholesterol, HDL, non-HDL, LDL <input type="checkbox"/> Follow-up lipid profile - Total cholesterol, HDL and non-HDL 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 and FT3 if indicated)
Other Tests		Other Chemistry Tests
<input type="checkbox"/> ECG <input type="checkbox"/> FIT (50 to 74 asymptomatic q2y) Copy to Colon Screening Program <input type="checkbox"/> FIT no copy to Colon Screening Program		<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"/> ALT <input type="checkbox"/> PSA - known or suspected prostate cancer (MSP billable) <input type="checkbox"/> B12 <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> T. Protein <input type="checkbox"/> PSA screening (self-pay) <input type="checkbox"/> Pregnancy test <input type="checkbox"/> B-HCG - quantitative
Additional Tests		
Standing orders: please indicate expiry and frequency		
Date of Collection	Time of Collection	
Collector	Signature of practitioner	Date signed



Patient Instructions	
<p>Several tests require the patient to fast prior to the test. Fasting means nothing to eat or drink (including gum and candy) for at least 8 to 12 hours. Water permitted in small quantities. Tests that require fasting are shaded. 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 greater than 4.5 mmol/L], independent of laboratory requirements.</p>	
Cholesterol / Triglyceride / HDL LDL / Lipid Panel	Fasting 8 to 12 hours Not Required unless specifically requested by Physician
Iron / TIBC / Homocysteine	Fasting 8 to 10 hours prior to the test.
Glucose Fasting	Fasting 8 to 10 hours prior to the test.
Glucose Tolerance Tests	Eat regular meals (adequate carbohydrate intake) for 3 days prior to the test. Do not eat or drink (including gum and candy), except water, for 8 hours prior to the test. Patient is required to remain at the Lab for the duration of the test.
Gestational diabetes screen (Glucose 1 hr, 50 g Drink)	Fasting NOT required. Blood is collected 1 hour after glucose drink is given to the patient. Patient is required to remain in the Lab for the duration of the test.
Therapeutic drug assays	Blood should be taken prior to next dose of medication.
Helicobacter Pylori breath test***	Do not eat or drink for 4 hours prior to test. Contact laboratory for a list of medications that interfere with testing.
24 hour urine	Instructions and containers are provided by the Laboratory.
Stool C&S, C.difficile, O&P, occult blood	
Urine culture (C&S)	
Sputum culture	
Semen analysis***	
Further testing information	Check with your physician or Laboratory or see the website below.

***Contact the laboratory to see if testing is available on-site!

<p>For detailed patient instructions and laboratory services go to: www.northernhealth.ca</p> <ul style="list-style-type: none"> • click on Services • click on Hospital Services • click on Lab Services • click on For Patients
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<p>For Administration Use Only Place Patient Label Here</p>	<p>For Administration Use Only Place Patient Label Here</p>
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