LifeLabs

Laboratory Requisition

This requisition form, when completed, constitutes a referral to LifeLabs laboratory physicians. It is for the use of authorized health care providers only.

THIS AREA IS FOR LAB USE

COMPLETE and ACCURATE information is required in all shaded areas.

Patient Surname (from BC Services Card)	First	Initial(s)	Date of Birth (dd / mm / yyyy)	Sex
D'ANIELLO	EMILIA FARA ELIZABETH		29 Apr 1996	◉ F ○ M

Bill to: ○ MSP ○ ICBC ○ WorkSafeBC ○ Patient ○ Other _____

Chart Number | Room # (LTC use only)

PHN BC 9879817865 I.D. Number _____

Patient Address	City, Province	Postal Code	Patient Telephone Number
1449 DELIA DR, PORT COQUITLAM BC V3C 2V9			(604)970-0682

Ordering Physician, Address, MSP Practitioner Number	Locum for: / Physician: / MSC #	C0 Number	Date/Time of Collection	Phlebotomist	Data Entry
Dr. Brian Montgomery MSP: 23556 3105 Murray St, Port Moody					

Date/Time/Name of Medication

Copy to: Address MSP
Port Moody Urgent And Primary Care
MT: PMUPCC, LL: C5495, VPP: C13650

Pregnant ○ Yes ○ No

☐ Fasting ____ hours prior to test

☐ Phone ☐ Fax

Telephone Requisition Received By

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 — On Anticoagulant? ○ Yes ○ No
- ☐ INR — Specify: _____
- ☐ 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)
- ☐ Glucose - random
- ☐ GTT - gestational diabetes screen (50 g load, 1 hour post-load)
- ☐ GTT - gestational diabetes confirmation (75 g load: fasting, 1 hour & 2 hour tests)
- ☐ GTT - non-gestational diabetes
- ☐ Hemoglobin A1c
- ☐ Albumin/creatinine ratio (ACR) - Urine

LIPIDS

✔ 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 > 4.5 mmol/L), independent of laboratory requirements.
- ☐ Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia)
- ☐ Follow-up Lipid Profile - Total, HDL & Non-HDL cholesterol only
- ☐ Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated)

THYROID FUNCTION

For other thyroid investigations, please order specific test below and provide diagnosis
- ☐ Monitor thyroid replacement therapy (TSH Only)
- ☐ Suspected Hypothyroidism (TSH first, fT4 if indicated)
- ☐ Suspected Hyperthyroidism (TSH first, fT4 & fT3 if indicated)

OTHER CHEMISTRY TESTS

- ☐ Sodium
- ☐ Potassium
- ☐ Albumin
- ☐ Alk phos
- ☐ ALT
- ☐ B12
- ☐ Bilirubin
- ☐ GGT
- ☐ T. Protein
- ☐ Creatinine/eGFR
- ☐ Calcium
- ☐ Creatine kinase (CK)
- ☐ PSA - Known or suspected prostate cancer (MSP billable)
- ☐ PSA screening (self-pay)
- ☐ Pregnancy Test
- ☐ ß-HCG - quantitative

The personal information collected on this form and any medical data subsequently developed will be used and disclosed only as permitted or required by the Personal Information Protection Act (and related acts and regulations) of British Columbia. LifeLabs 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

On Antibiotics? ○ Yes ○ No Specify: _____

☑ Throat ☐ Sputum ☐ Blood ☐ Urine

☐ 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) by NAAT

Source/site: ☐ Urethra ☐ Cervix ☐ Urine ☐ Vagina ☐ Throat ☐ Rectum ☐ Other: _____

GONORRHEA (GC) CULTURE

Source/site: ☐ Cervix ☐ Urethra ☐ Throat ☐ Rectum ☐ Other: _____

STOOL SPECIMENS

History of bloody stools? ☐ Yes
- ☐ C. difficile testing ☐ Stool culture ☐ Stool ova & parasite exam
- ☐ Stool ova & parasite (high risk, submit 2 samples)

DERMATOPHYTES
- ☐ Dermatophyte culture ☐ KOH prep (direct exam)

Specimen ☐ Skin ☐ Nail ☐ Hair

Site: _____

MYCOLOGY

☐ Yeast ☐ Fungus Site: _____

URINE TESTS
- ☐ Macroscopic → microscopic if dipstick positive
- ☐ Macroscopic → urine culture if pyuria or nitrite present
- ☐ Macroscopic (dipstick) ☐ Microscopic*

*Clinical information for microscopic required: _____

HEPATITIS SEROLOGY

☐ **Acute viral hepatitis undefined etiology**
Hepatitis A (anti-HAV IgM)
Hepatitis B (HBsAg, ± anti-HBc)
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

(For other hepatitis markers, please order specific test(s) below)

HIV SEROLOGY

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

OTHER TESTS Standing Orders include expiry & frequency
- ☐ ECG
- ☐ FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program
- ☐ FIT No copy to Colon Screening Program

Standing Order requests - expiry and frequency must be indicated

Date: 31 Aug 2023

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

Practitioner Signature