

**COMPLETE and ACCURATE information is required in all shaded areas.**

Patient Surname (from BC Services Card) BOSA		First LINDA	Initial(s)	Date of Birth 15 Feb 1967		Sex <input checked="" type="radio"/> F <input type="radio"/> M
Bill to: <input type="radio"/> MSP <input type="radio"/> ICBC <input type="radio"/> WorkSafeBC <input type="radio"/> Patient <input type="radio"/> Other				Chart Number		Room # (LTC use only)
PHN BC 9056703145		I.D. Number		Patient Telephone Number (250)739-3699		
Patient Address 720 POIRIER ST, COQUITLAM BC V3J 6B7		City, Province		Postal Code		
Ordering Physician, Address, MSP Practitioner Number Dr. Brian Montgomery MSP: 23556 3105 Murray St, Port Moody		Locum for: Physician: MSC #	C0 Number	Date/Time of Collection Phlebotomist Data Entry		
Copy to: Address: MSP Port Moody Urgent And Primary Care MT: PMUPCC, LL: C5495, VPP: C13650		Pregnant <input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Fasting hours prior to test	<input type="checkbox"/> Phone <input type="checkbox"/> 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](http://www.BCGuidelines.ca))

<b>HEMATOLOGY</b> <input type="checkbox"/> Hematology profile <input checked="" type="checkbox"/> On Anticoagulant? <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> INR Specify: _____ <input type="checkbox"/> Ferritin (query iron deficiency) <input checked="" type="checkbox"/> HFE - Hemochromatosis (check ONE box only) <input type="checkbox"/> Confirm diagnosis (ferritin first, ± TS, ± DNA testing) <input type="checkbox"/> Sibling/parent is C282Y/C282Y homozygote (DNA testing)		<b>MICROBIOLOGY</b> LABEL ALL SPECIMENS WITH PATIENT'S FIRST AND LAST NAME, DOB AND/OR PHN & SITE <b>ROUTINE CULTURE</b> On Antibiotics? <input type="radio"/> Yes <input type="radio"/> No Specify: _____ <input checked="" type="checkbox"/> Throat <input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Superficial Wound, Site: _____ <input type="checkbox"/> Deep Wound, Site: _____ <input type="checkbox"/> Other: _____ <b>VAGINITIS</b> <input type="checkbox"/> Initial (smear for BV & yeast only) <input type="checkbox"/> Chronic/recurrent (smear culture, trichomonas) <input type="checkbox"/> Trichomonas testing <b>GROUP B STREP SCREEN (Pregnancy only)</b> <input type="checkbox"/> Vagino-anorectal swab <input type="checkbox"/> Penicillin allergy <b>CHLAMYDIA (CT) &amp; GONORRHEA (GC) by NAAT</b> 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: _____ <b>GONORRHEA (GC) CULTURE</b> Source/site: <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Throat <input type="checkbox"/> Rectum <input type="checkbox"/> Other: _____ <b>STOOL SPECIMENS</b> History of bloody stools? <input type="checkbox"/> Yes <input type="checkbox"/> C. difficile testing <input type="checkbox"/> Stool culture <input type="checkbox"/> Stool ova & parasite exam <input type="checkbox"/> Stool ova & parasite (high risk, submit 2 samples) <b>DERMATOPHYTES</b> <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: _____ <b>MYCOLOGY</b> <input type="checkbox"/> Yeast <input type="checkbox"/> Fungus Site: _____		<b>URINE TESTS</b> <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 information for microscopic required: <b>HEPATITIS SEROLOGY</b> <input type="checkbox"/> Acute viral hepatitis undefined etiology Hepatitis A (anti-HAV IgM) Hepatitis B (HBsAg, ± anti-HBc) Hepatitis C (anti-HCV) <input type="checkbox"/> Chronic viral hepatitis undefined etiology Hepatitis B (HBsAg, anti-HBc, anti-HBs) Hepatitis C (anti-HCV) Investigation of hepatitis immune status <input type="checkbox"/> Hepatitis A (anti-HAV, total) <input type="checkbox"/> Hepatitis B (anti-HBs) Hepatitis marker(s) <input type="checkbox"/> HBsAg (For other hepatitis markers, please order specific test(s) below)			
<b>CHEMISTRY</b> <input type="checkbox"/> Glucose - fasting (see reverse for patient instructions) <input type="checkbox"/> Glucose - random <input type="checkbox"/> GTT - gestational diabetes screen (50 g load, 1 hour post-load) <input type="checkbox"/> GTT - gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour tests) <input type="checkbox"/> GTT - non-gestational diabetes <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> Albumin/creatinine ratio (ACR) - Urine <b>LIPIDS</b> <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 > 4.5 mmol/L) independent of laboratory requirements. <input type="checkbox"/> Full Lipid Profile - Total, HDL, Non-HDL, LDL cholesterol & triglycerides (Baseline or follow-up of complex dyslipidemia) <input type="checkbox"/> Follow-up Lipid Profile - Total, HDL & Non-HDL cholesterol only <input type="checkbox"/> Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated)		<b>THYROID FUNCTION</b> For other thyroid investigations, please order specific test below and provide diagnosis: <input type="checkbox"/> Monitor thyroid replacement therapy (TSH Only) <input type="checkbox"/> Suspected Hypothyroidism (TSH first, T4 & T3 if indicated) <input type="checkbox"/> Suspected Hyperthyroidism (TSH first, T4 & T3 if indicated)		<b>OTHER CHEMISTRY TESTS</b> <input type="checkbox"/> Sodium <input type="checkbox"/> Creatinine/SGFR <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"/> PSA - Known or suspected prostate cancer (MSP billable) <input type="checkbox"/> ALT <input type="checkbox"/> PSA screening (self-pay) <input type="checkbox"/> B12 <input type="checkbox"/> Pregnancy Test <input type="checkbox"/> Erythropoietin <input type="checkbox"/> 6-HCG - quantitative <input type="checkbox"/> GGT <input type="checkbox"/> T. Protein		<b>HIV SEROLOGY</b> <input 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	
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 <a href="http://www.lifelabs.com">www.lifelabs.com</a> . Use of this form implies consent for the use of de-identified patient data and specimens for quality assurance purposes.		Date 31 Aug 2023 Requisition is valid for one year from the date of issue.		Standing Order requisition: expiry and frequency must be indicated. Practitioner Signature: _____			