LifeLabs®

MANDATORY

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) 1 | First | Initial(s) | Date of Birth 2 DAY / MONTH / YEAR | Sex 3 ☐ F ☐ M

Bill t 4 MSP ☐ ICBC ☐ WorkSafeBC ☐ Patient ☐ Other

PHN 5 I.D. Number | Chart Number 6 | Room # (LTC use only) 7

Patient Address 8 | City, Province | Postal Code | Patient Telephone Number 9

Ordering Physician, Address, MSP Practitioner Number 10 | Locum for: Physician 11 MSC # | C0 Number | Date/Time of Collection 17 | Phlebotomist | Data Entry

Date/T me of Medication 18

Copy to: Address, MSP Practitioner Number 12 | Pregnant ☐ Yes 13 | ☐ Fasting 14 hours pr | ☐ Phone ☐ Fax 15 | Telephone Requisition Received By: INITIAL/DATE

Diagnosis and indications for guideline protocol and special tests 16

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) 19

- ☐ **Confirm diagnosis (ferritin first, ± TS, ± DNA test)**
- ☐ 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 test)
- ☐ 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 20

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 21

☐ Yeast ☐ Fungus Site: _____

Date 24

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

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 their 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

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Standing Order requests - expiry and frequency must be in

Practitioner Signature: 25

1. **Patient Name**
   Provide patient's last name, first name, initials **as they appear on the patient's BC Services Card** or other Government-issued ID
2. **Patient Date of Birth**
   Date of Birth – Day-Month-Year
3. **Patient Sex**
   Indicate M-Male or F-Female
4. **Bill To**
   Check the box for type of billing requested. Select Other for billing types not listed.
5. **PHN / ID Number**
   Provide PHN for MSP billing or ID number for other billing types.
6. **Chart Number**
   Provide patient chart number if required.
7. **Room Number**
   For LTC patients, provide patient room number
8. **Patient Address**
   Provide full patient address, including city and postal code.
9. **Patient Telephone Number**
   Provide current contact phone number.
10. **Ordering HCP**
    Provide Ordering HCP MSP number, full first and last name, and complete address for report delivery. **Results are reported to the ordering HCP at the address provided via the delivery method specified in their client file**.
11. **Locum HCP**
    If ordering HCP is locuming for another HCP, provide the full name and MSP number of the other HCP
12. **Copy-to**
    All copy-to recipients must be specified here by the ordering HCP. Provide the full first name, last name, and MSP number of copy-to HCPs. For copy-to entities, provide the full name and address. **Results will not be copied to HCPs or entities if copy-to information is illegible or incomplete.**
13. **Pregnancy status**
    Provide pregnancy status, if relevant to the Test(s) ordered.
14. **Fasting**
    Indicate whether fasting is required, if relevant to the test(s) ordered.
15. **Phone and Fax**
    Complete if results are required by phone or fax in addition to routine reporting.
16. **Diagnosis**
    Provide the diagnosis and indications for guideline protocol and special tests. Tests with shaded tick boxes require a diagnosis or clinical indication. Consult Provincial Guidelines and protocols (www.bcguidelines.com). **Tests requested without required clinical information will not be processed.**
17. **Date of Collection**
    For samples collected and submitted to LifeLabs for testing, provide the date and time of sample collection.
18. **Medication**
    Provide the name of the medication, and date and time of last dose, if relevant to the test(s) ordered.
19. **Anticoagulant**
    For coagulation test(s), indicate whether the patient is taking an anticoagulant, and provide the anticoagulant name.
20. **Antibiotics**
    For microbiology testing, indicate whether the patient is taking antibiotics, and provide the antibiotic name.
21. **Dermatophyte and Mycology**
    Specify the sample site
22. **Other Tests**
    List other test(s) ordered which do not have a tick box elsewhere on the requisition.
23. **Standing Orders**
    List the frequency and expiry date of any test(s) to be repeated. Standing order requests must meet the requirements stated in the BC Provincial Standing Order Policy.
24. **Date**
    Provide the date the testing was ordered. For post-dated requisitions, the date may not be more than 6 months in the future.
25. **Signature**
    Ordering HCP signature. Electronic signature is acceptable.