

COMPLETE and ACCURATE information is required in all shaded areas.

Patient Surname (from CareCard)		First	Initial(s)	Date of Birth		Sex
Bill to: <input type="checkbox"/> MSP <input type="checkbox"/> ICBC <input type="checkbox"/> WorkSafeBC <input type="checkbox"/> Patient <input type="checkbox"/> Other _____		PHN _____		DAY	MONTH	YEAR
Patient Address		City, Province	Postal Code	Patient Telephone Number		
Ordering Physician, Address, MSP Practitioner Number		Locum for: Physician _____	C0 Number _____	Date/Time of Collection	Phlebotomist	Data Entry
Copy to: Address, MSP Practitioner Number		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fasting _____ hours prior to test	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	MICROBIOLOGY	URINE TESTS
<input type="checkbox"/> Hematology profile <input type="checkbox"/> PT-INR <input type="checkbox"/> On Warfarin? <input type="checkbox"/> Ferritin (query iron deficiency) 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)	LABEL ALL SPECIMENS WITH PATIENT'S FIRST AND LAST NAME, DOB AND/OR PHN & SITE ROUTINE CULTURE List current antibiotics: _____ <input type="checkbox"/> Throat <input type="checkbox"/> Sputum <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 & 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) <input type="checkbox"/> CT & GC Testing Source/site: <input type="checkbox"/> Urethra <input type="checkbox"/> Cervix <input type="checkbox"/> Urine <input type="checkbox"/> GC culture: <input type="checkbox"/> Throat <input type="checkbox"/> Rectal <input type="checkbox"/> Other: _____ STOOL SPECIMENS History of bloody stools? <input type="checkbox"/> Yes <input type="checkbox"/> No <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, 2 samples)	<input type="checkbox"/> Urine culture - list current antibiotics: _____ <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 <input type="checkbox"/> Special case (if ordered together)
CHEMISTRY	LIPIDS	HEPATITIS SEROLOGY
<input type="checkbox"/> Glucose - fasting (see reverse for patient instructions) <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 & 2 hour test) <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> Albumin/creatinine ratio (ACR) - Urine	One box only. For other lipid investigations, please order under Other Tests section and provide diagnosis. <input type="checkbox"/> Baseline cardiovascular risk assessment or follow-up (Lipid profile, Total, HDL, non-HDL & LDL Cholesterol, Triglycerides, fasting) <input type="checkbox"/> Follow-up of treated hypercholesterolemia (Total, HDL & non-HDL Cholesterol, fasting not required) <input type="checkbox"/> Follow-up of treated hypercholesterolemia (ApoB only, fasting not required) <input type="checkbox"/> Self-pay lipid profile (non-MSP billable, fasting)	<input checked="" type="checkbox"/> One box only. For other Hepatitis Markers, please order under Other Tests section. <input type="checkbox"/> Acute viral hepatitis undefined etiology Hepatitis A (anti-HAV IgM) Hepatitis B (HBsAg, plus anti-HBc if required) Hepatitis C (anti-HCV) <input type="checkbox"/> Chronic viral hepatitis undefined etiology Hepatitis B (HBsAg, anti-HBc, anti-HBs) Hepatitis C (anti-HCV)
THYROID FUNCTION	OTHER CHEMISTRY TESTS	HIV SEROLOGY
<input checked="" type="checkbox"/> One box only. For other thyroid investigations, please order under Other Tests section and provide diagnosis. <input type="checkbox"/> Monitor thyroid replacement therapy (TSH Only) <input type="checkbox"/> Suspected Hypothyroidism TSH first (plus FT4 if required) <input type="checkbox"/> Suspected Hyperthyroidism, TSH first (plus FT4 or FT3 if required)	<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"/> PSA - Known or suspected prostate cancer (MSP billable) <input type="checkbox"/> ALT <input type="checkbox"/> PSA screening (self-pay) <input type="checkbox"/> GGT <input type="checkbox"/> Pregnancy Test <input type="checkbox"/> T. Protein <input type="checkbox"/> Serum <input type="checkbox"/> Urine	<input type="checkbox"/> HIV Serology (patient has legal right to choose not to have their name and address reported to public health – non-nominal reporting) <input type="checkbox"/> Non-nominal reporting
DERMATOPHYTES	MYCOLOGY	OTHER TESTS
<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: _____	<input type="checkbox"/> Yeast <input type="checkbox"/> Fungus Site: _____	<input type="checkbox"/> ECG <input type="checkbox"/> Fecal Occult Blood (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program. <input type="checkbox"/> Fecal Occult Blood (other indications)
Date _____ Requisition is valid for one year from the date of issue.		Standing Order requests - expiry and frequency must be indicated Physician Signature _____

