

# **Public Health Laboratory**

655 West 12th Avenue, Vancouver, BC V5Z 4R4 www.bccdc.ca/publichealthlab

# **Serology Screening Requisition**



#### Section 1 - Patient/Provider Information (Two matching unique patient identifiers on sample container and requisition are required for sample processing)

PERSONAL HEALTH NUM (or out-of province Health Number		ORDERING PRACTITIONER Name and MSC#	DATE RECEIVED
PATIENT SURNAME		Address of report delivery	
PATIENT FIRST AND MIDDLE NAME			LABORATORY USE ONLY
DOB (DD/MMM/YYYY)	SEX M F X U (Unk)		
PATIENT ADDRESS		ADDITIONAL COPIES TO PRACTITIONER / CLINIC: (Name, Address / MSC#/ PHSA Client#) (Limit of 3 copies available) 1.	OUTBREAK ID
		2.	SAMPLE REF. NO.
СІТҮ		- 3.	DATE COLLECTED (DD/MMM/YYYY)
PROVINCE	POSTAL CODE		TIME COLLECTED (HH:MM)

#### **Section 2 - Clinical Information**

Reason for Test		<b>Clinical Information</b>	1		
	Outbreak/Cluster/Event	Rash symptoms	STI contact		STI symptoms
Prenatal	Other, specify:	Recent Travel History (Date/Location)			Onset Date (DD/MMM/YYYY)

### Section 3 - Test(s) Requested (Note: Codes for PHSA Labs Use Only)

PRENATAL SCREENING	HEPATITIS SEROLOGY	OTHER SEROLOGY				
(PRENAT)	(Serum)	Immunity	Acute			
HIV HIVCC	Acute - undefined etiology HBsAg, Anti-HBc Total, HEPSB		CMV IgM CMVSP			
HIV Non-Nominal Reporting HIVCC	Anti-HBs, Anti-HCV, Anti-HAV IgM		<b>J</b>			
HBsAg HBVP		EBV IgG EBGSB	EBV IgM EBVSP			
Rubella IgG	Chronic - undefined etiology HBsAg, Anti-HBc Total Anti-HBs, Anti-HCV	Measles IgG MIGB (Rubeola)	Measles IgM MEASP (Rubeola)			
Syphilis Antibody	Hepatitis B Screen Panel	Mumps IgG MUIGB	Mumps IgM MUMPS			
(1st Trimester)	HBsAg, Anti-HBs, Anti-HBc Total	Parvo B19 lgG PARVGB	Parvo B19 IgM PARVP			
Other Tests, specify:	Anti-hepatitis A Total	Rubella IgG RUBEB	Rubella IgM			
	(Immune Status)	Varicella IgG VZIGB				
	Anti-hepatitis A IgM HAVMB					
PERINATAL SYPHILIS	(Acute Infection)					
Perinatal PDSYP	HBsAg Only HBVSA	H. pylori IgG	HSV Type Specific IgG HSVTSS			
(>35 weeks/at delivery)	Anti-HBs HBSAB (Immune Status)	HTLV I / II HTLVB				
SYPHILIS ANTIBODY	HBeAg HBXEA					
Routine TPE	(Therapeutic Monitoring)	OTHER TESTS (Specify)				
(Non Prenatal)	Anti-HBe HBXEB					
HIV (Non Prenatal)	(Therapeutic Monitoring)	For other available tests and sample collection information, consult the Public Health				
	Anti-HCV HEPCB	Laboratory's <i>eLab Handbook</i> at www.elabhandbook.info/PHSA/Default.aspx				
HIV HIVCC	HEPATITIS C PCR					
Note: Patient has the legal right to choose not to have their name reported to public	(EDTA Plasma)	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 healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use				
health = non-nominal reporting	HCV RNA Quantitative HPCRBB					
Non-Nominal HIVCC	(For diagnosis and monitoring)					
Reporting Requested	HCV Genotyping HEPCRB (For treatment)	and disclosure in accordance with the Personal Information Information and Protection of Privacy Act and may be	on Protection Act and when applicable the Freedom of			



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## **1 - Patient/Provider Information**

For physicians who work at more than one location, please provide an address for delivery.

## - Additional Copies To

The Ordering Physician will receive one copy of the report. Each physician or client listed under Additional Copies To: will receive a copy of the report.

## 2 - Clinical Information

Please fill in as completely as possible.

BC Centre for Disease Control As agency of the Producted Health Services Archeoly		st 12th Avenue, Vancou ccdc.ca/publichealthlal		Serolog	gy Screening	g Requisitio	
Section 1 - Patient/Prov		ormation (Twomat			ontainer and requisit	1	ample processing
PERSONAL HEALTH NUMBER (or out-of province Health Number and p	t province)	1	ORDERING PRACT	TITIONER		DATE RECEIVED	
PATIENT SURNAME			Address of report delivery				
PATIENT FIRST AND MIDDLE NAME						LABOR	
DOB SEX		🗌 F 🔄 X 🗌 U (Unk)	I do not require a copy of the report I am a Locum <sup>1</sup> If Locum, include name of Practitioner you are covering for			USE ONLY	
PATIENT ADDRESS			ADDITIONAL COP Name, Address / MSCW/	PIES TO PRACTITIONER / PHSA Client#) (Limit of 3 copies	CLINIC: savailable)		
			1.			OUTBREAK ID	
CITY			2.			SAMPLE REF. NO.	
PROVINCE	POSTAL	CODE	3.			DATE COLLECTED (DD/MMM/YYYY)	
	100114					TIME COLLECTED (HH:MM)	
ection 2 - Clinical Infor	mation						
Reason for Test				Clinical Information			
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				Recent Travel History (	Jano Lotalitori j		
ection 3 - Test(s) Reque	ested (No	ote: Codes for PHSA	EROLOGY	OTHER SEROLOGY			
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## 3 - Prenatal Testing\*

-If nominal HIV testing, please provide 2 serum separator tubes. -If non-nominal HIV testing, please provide 3 serum separator tubes.

## 4 - Perinatal Testing (Syphilis only)

-Please provide 1 serum separator tube.

## 5 - HIV Testing\*

-If nominal HIV testing, please provide 1 serum separator tube. -If non-nominal HIV testing, please provide 2 serum separator tubes.

## **6 - Hepatitis Serology Testing**

-Please provide 1 serum separator tube.

### 7 - Combinations of Syphilis, nominal HIV, Hepatitis Serology and Other Serology

-Please provide 1 serum separator tube. -If non-nominal reporting for HIV\* is requested, please provide an additional serum separator tube (2 tubes in total).

## 8 - Hepatitis C PCR Testing

- For HCV RNA and HCV genotyping requests, please provide 1 EDTA plasma (lavender-top) tube.

## 9 - Other Tests

-Indicate all additional tests requested. Please consult the PHSA Laboratories <u>eLab Handbook</u> for specimen requirements.

\*Note for HIV patient has the legal right to choose not to have their name reported to public health.