Completion of Laboratory Requisition and Labelling Specimen

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This document is for clinicans who may be collecting specimens from clients during the COVID-19 response.

Laboratory Requisition Requirements

Requisition MUST contain the following:

Client information

- Client's full legal name
- Numerical Identifier (PHN - "if out of province identify PHN and Province" [e.g., XXXXXXXXX-AB])
- Date of Birth
- Gender
- Client address and contact phone #

Diagnosis information

- "SYMPTOMATIC, COVID-19 SCREEN TESTING" with one of the below "identification of the reported exposure"
  1. Confirmed Contact
  2. Notification of Exposure
  3. Household Contact
  4. Travel outside of Canada

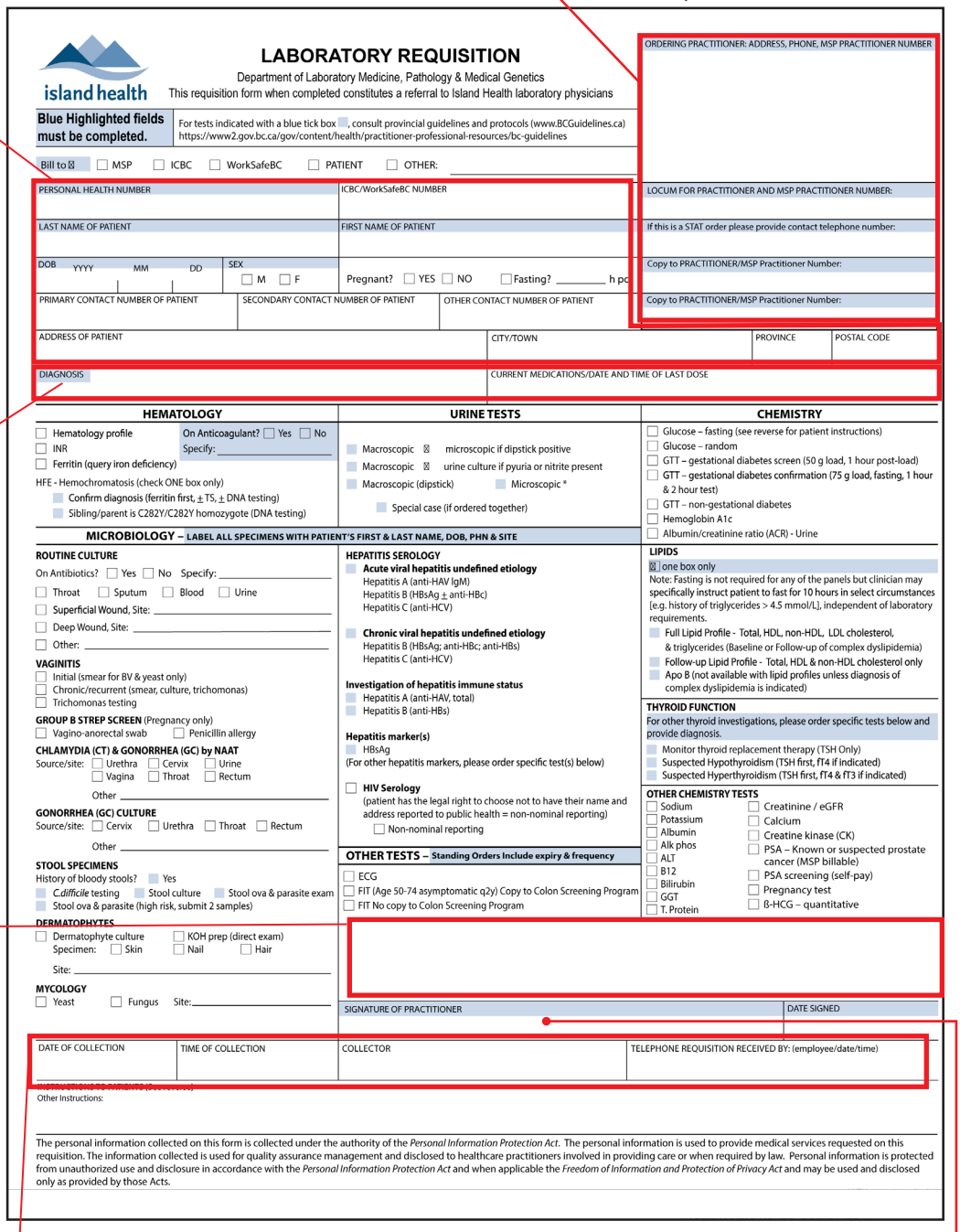
Other Tests information

- Swab site location "Nose"
- "Symptomatic COVID-19"

Patient Priority	Label colour
HCW1	Magenta
HCW2	Green
LTC	White
OBK	White
HOSP	Yellow
CMM	White

Provider information

- Ordering Provider Name, Address, Phone # and MSP #



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LABORATORY REQUISITION

Department of Laboratory Medicine, Pathology & Medical Genetics

This requisition form when completed constitutes a referral to Island Health laboratory physicians

Blue Highlighted fields must be completed.

For tests indicated with a blue tick box, consult provincial guidelines and protocols (www.BCGuidelines.ca) https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

Bill to ☒ ☐ MSP ☐ ICBC ☐ WorkSafeBC ☐ PATIENT ☐ OTHER:

PERSONAL HEALTH NUMBER | ICBC/WorkSafeBC NUMBER

LAST NAME OF PATIENT | FIRST NAME OF PATIENT

DOB YYYY MM DD | SEX ☐ M ☐ F | Pregnant? ☐ YES ☐ NO ☐ Fasting? _____ h pc

PRIMARY CONTACT NUMBER OF PATIENT | SECONDARY CONTACT NUMBER OF PATIENT | OTHER CONTACT NUMBER OF PATIENT

ADDRESS OF PATIENT | CITY/TOWN | PROVINCE | POSTAL CODE

DIAGNOSIS | CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE

ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER

LOCUM FOR PRACTITIONER AND MSP PRACTITIONER NUMBER:

If this is a STAT order please provide contact telephone number:

Copy to PRACTITIONER/MSP Practitioner Number:

Copy to PRACTITIONER/MSP Practitioner Number:

HEMATOLOGY

☐ Hematology profile
☐ INR
☐ Ferritin (query iron deficiency)
On Anticoagulant? ☐ Yes ☐ No
Specify: _____

HFE - Hemochromatosis (check ONE box only)
☐ Confirm diagnosis (ferritin first, ± TS, ± DNA testing)
☐ Sibling/parent is C282Y/C282Y homozygote (DNA testing)

URINE TESTS

☐ Macroscopic ☒ microscopic if dipstick positive
☐ Macroscopic ☒ urine culture if pyuria or nitrite present
☐ Macroscopic (dipstick) ☐ Microscopic *
☐ Special case (if ordered together)

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

MICROBIOLOGY – LABEL ALL SPECIMENS WITH PATIENT'S FIRST & LAST NAME, DOB, 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: _____

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**
(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

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 tests 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

SIGNATURE OF PRACTITIONER | DATE SIGNED

DATE OF COLLECTION | TIME OF COLLECTION | COLLECTOR | TELEPHONE REQUISITION RECEIVED BY: (employee/date/time)

Other Instructions:

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 and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.

Specimen Collection Documentation

- Date of Collection
- Time of Collection
- Collector Name and Designation (RN, RPN, LPN)
- Collector Phone #

Signature of Practitioner not required during COVID-19 Pandemic

Note: If there is no requisition, lab will call for one to be faxed to them before the testing can start.

Completion of Laboratory Requisition and Labelling Specimen

Follow current IPAC protocols when handling specimens.

Laboratory Requisition Requirements

To prioritize testing, label the requisition as coming from:

HCW1 – Health Care Worker – Direct Care (magenta label)
- Essential service providers (incl. first responders)

HCW2 – Health Care Worker – Non Direct Care (green label)

LTC – Long Term Care Facility (white label)

OBK – Outbreak (white label)
- Including people who are homeless or have unstable housing

HOSP – Hospital - Inpatient, (yellow label)
- Emergency Department (with intent to admit)
- Symptomatic pregnant woman in their 3rd trimester
- Renal patients
- Cancer patients receiving treatment

CMM – Community - Outpatient (white label)
- Residents of remote, isolated or indigenous communities
- Primary Care Centres and Doctor's office
- Emergency Department (non-admitted)
- Surveillance
- Returning travellers identified at point of entry.

Labelling Specimen Requirements

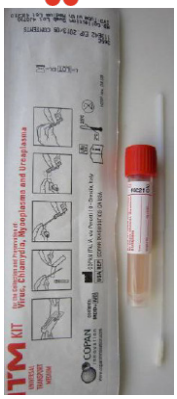
1. Label the sample.

The PPID sample label MUST contain:
- Patient's full legal name
- Numerical Identifier (PHN - "if out of province identify PHN and Province" [e.g., XXXXXXXXX-AB])
- Date of Birth
- Origin of sample (nose)
- Date of collection
- Time of collection
- List specific priority (HCW1, HCW2, LTC, OBK, HOSP, CMM).

2. Insert the specimen inside a BioHazard bag and seal.
3. Insert the completed Laboratory Requisition into the front pouch of the BioHazard bag.
4. Place specified priority label on outside of biohazard bag (HCW1, HCW2, LTC, OBK, HOSP, CMM). See example.

Red Swab for children 10 years old and younger ONLY

Blue Swab or Aptima Swab for children 11 years and older, and Adults

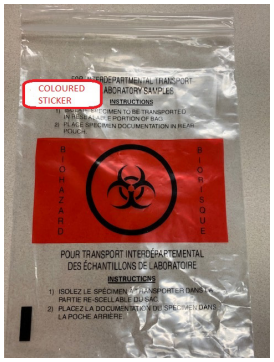


COPAN red-top with Universal Transport Media

COPAN blue-top with Universal Transport Media

or

Aptima Multi-test Sample Collection Kit (Although a genital swab, it has been approved for NP swabbing.)



Note: If a sample is not labeled (or not labeled correctly) it will be rejected.