

## MEMORANDUM

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**DATE:** May 25, 2020

**FROM:** Dr. Steve Loken, Medical Director and Department Head, Laboratory Medicine  
Catriona Gano, Director, Laboratory Medicine

**SUBJECT:** Vancouver Island COVID testing

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In an effort to support the most efficient turnaround time and surveillance for COVID testing on Vancouver Island, effective June 1<sup>st</sup>, 2020 all COVID test requests will be processed by Island Health at the Victoria General Hospital. This means that COVID testing that was historically processed by Life Labs will be redirected to Island Health for processing.

The attached document below outlines the information that is needed for each COVID swab and requisition. Please ensure these instructions are followed so prioritization of COVID testing can occur based on the BCCDC priority categories.

Sincerely,



Dr Steve Loken  
Medical Director and Department Head



Catriona Gano  
Director

# Completion of Laboratory Requisition and Labelling



This document is for clinicians 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 "nasopharyngeal"
- "Symptomatic COVID-19"

### Patient Priority

- HCW1
- HCW2
- LTC
- OBK
- HOSP
- CMM
- CGT

### Provider information

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

### LABORATORY REQUISITION

Department of Laboratory Medicine, Pathology & Medical Genetics  
This requisition form when completed constitutes a referral to Island Health laboratory physicians

ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER

**Blue Highlighted fields must be completed.** For tests indicated with a blue tick box , consult provincial guidelines and protocols ([www.BCGuidelines.ca](http://www.BCGuidelines.ca)) <https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines>

Bill to  MSP  IBCB  WorkSafeBC  PATIENT  OTHER: \_\_\_\_\_

<small>PERSONAL HEALTH NUMBER</small>		<small>ICBC/WorkSafeBC NUMBER</small>		<small>LOCUM FOR PRACTITIONER AND MSP PRACTITIONER NUMBER:</small>	
<small>LAST NAME OF PATIENT</small>			<small>FIRST NAME OF PATIENT</small>		
<small>DOB YYYY MM DD SEX <input type="checkbox"/> M <input type="checkbox"/> F Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO Fasting? _____ h pc</small>					
<small>PRIMARY CONTACT NUMBER OF PATIENT</small>		<small>SECONDARY CONTACT NUMBER OF PATIENT</small>		<small>OTHER CONTACT NUMBER OF PATIENT</small>	
<small>ADDRESS OF PATIENT</small>			<small>CITY/TOWN</small>		<small>PROVINCE</small>
<small>POSTAL CODE</small>					
<small>DIAGNOSIS</small>			<small>CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE</small>		

<p><b>HEMATOLOGY</b></p> <p><input type="checkbox"/> Hematology profile <input type="checkbox"/> On Anticoagulant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> INR Specify: _____</p> <p><input type="checkbox"/> Ferritin (query iron deficiency)</p> <p><input checked="" type="checkbox"/> HFE - Hemochromatosis (check ONE box only)</p> <p><input type="checkbox"/> Confirm diagnosis (ferritin first, <math>\pm</math> TS, <math>\pm</math> DNA testing)</p> <p><input type="checkbox"/> Sibling/parent is C282Y/C282Y homozygote (DNA testing)</p>	<p><b>URINE TESTS</b></p> <p><input type="checkbox"/> Macroscopic <input type="checkbox"/> microscopic if dipstick positive</p> <p><input type="checkbox"/> Macroscopic <input type="checkbox"/> urine culture if pyuria or nitrite present</p> <p><input type="checkbox"/> Macroscopic (dipstick) <input type="checkbox"/> Microscopic *</p> <p><input type="checkbox"/> Special case (if ordered together)</p>	<p><b>CHEMISTRY</b></p> <p><input type="checkbox"/> Glucose - fasting (see reverse for patient instructions)</p> <p><input type="checkbox"/> Glucose - random</p> <p><input type="checkbox"/> GTT - gestational diabetes screen (50 g load, 1 hour post-load)</p> <p><input type="checkbox"/> GTT - gestational diabetes confirmation (75 g load, fasting, 1 hour &amp; 2 hour test)</p> <p><input type="checkbox"/> GTT - non-gestational diabetes</p> <p><input type="checkbox"/> Hemoglobin A1c</p> <p><input type="checkbox"/> Albumin/creatinine ratio (ACR) - Urine</p>
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**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  No

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  $\pm$  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  Creatinine / eGFR

Potassium  Calcium

Albumin  Creatinine kinase (CK)

Alk phos  PSA - Known or suspected prostate cancer (MSP billable)

ALT  PSA screening (self-pay)

B12  Bilirubin

GGT  Pregnancy test

T-Protein  B-HCG - quantitative

SIGNATURE OF PRACTITIONER \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

<small>DATE OF COLLECTION</small>	<small>TIME OF COLLECTION</small>	<small>COLLECTOR</small>	<small>TELEPHONE REQUISITION RECEIVED BY: (employee/date/time)</small>
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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 whom 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.

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

- Essential service providers (incl. first responders)

**HCW2** – Health Care Worker – Non Direct Care

**LTC** – Long Term Care Facility

**OBK** – Outbreak

- Including people who are homeless or have unstable housing

**HOSP** – Hospital - Inpatient

- Emergency Department (with intent to admit)
- Symptomatic pregnant woman in their 3rd trimester
- Renal patients
- Cancer patients receiving treatment

**CMM** – Community - Outpatient

- 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.

**CGT** – People living in a congregate setting such as work camps, shelters, group homes and correctional facilities.

## Labelling Specimen Requirements

### 1. Label the sample.

The 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, CGT).



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

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, CGT). See example.



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