

## 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			
<b>Blue Highlighted fields must be completed.</b> 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		<b>ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER</b>	
Bill to: <input type="checkbox"/> MSP <input type="checkbox"/> IBCB <input type="checkbox"/> WorkSafeBC <input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER:		LOCUM FOR PRACTITIONER AND MSP PRACTITIONER NUMBER:	
PERSONAL HEALTH NUMBER LAST NAME OF PATIENT FIRST NAME OF PATIENT 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 PRIMARY CONTACT NUMBER OF PATIENT SECONDARY CONTACT NUMBER OF PATIENT OTHER CONTACT NUMBER OF PATIENT ADDRESS OF PATIENT CITY/TOWN PROVINCE POSTAL CODE		If this is a STAT order please provide contact telephone number: Copy to PRACTITIONER/MSP Practitioner Number: Copy to PRACTITIONER/MSP Practitioner Number:	
<b>DIAGNOSIS</b> CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE			
<b>HEMATOLOGY</b> <input type="checkbox"/> Hematology profile <input type="checkbox"/> On Anticoagulant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> INR Specify: <input type="checkbox"/> Ferritin (query iron deficiency) <input type="checkbox"/> HFE - Hemochromatosis (check ONE box only) <input type="checkbox"/> Confirm diagnosis (ferritin first, $\pm$ TS, $\pm$ DNA testing) <input type="checkbox"/> Sibling/parent is C282Y/C282Y homozygote (DNA testing)		<b>URINE TESTS</b> <input type="checkbox"/> Macroscopic <input type="checkbox"/> microscopic if dipstick positive <input type="checkbox"/> Macroscopic <input type="checkbox"/> urine culture if pyuria or nitrite present <input type="checkbox"/> Macroscopic (dipstick) <input type="checkbox"/> Microscopic * <input type="checkbox"/> Special case (if ordered together)	
<b>MICROBIOLOGY - LABEL ALL SPECIMENS WITH PATIENT'S FIRST &amp; LAST NAME, DOB, PHN &amp; SITE</b> <b>ROUTINE CULTURE</b> On Antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: <input type="checkbox"/> Throat <input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Superficial Wound, Site: <input type="checkbox"/> Deep Wound, Site: <input type="checkbox"/> Other: <b>VAGINITIS</b> <input type="checkbox"/> Initial (smear for BV & yeast only) <input type="checkbox"/> Chronic/recurrent (smear, culture, trichomonas) <input type="checkbox"/> Trichomonas testing <b>GROUP B STREP SCREEN</b> (Pregnancy only) <input type="checkbox"/> Vagino-ano-rectal swab <input type="checkbox"/> Penicillin allergy <b>CHLAMYDIA (CT) &amp; GONORRHEA (GC) by NAAT</b> Source/site: <input type="checkbox"/> Urethra <input type="checkbox"/> Cervix <input type="checkbox"/> Urine <input type="checkbox"/> Vagina <input type="checkbox"/> Throat <input type="checkbox"/> Rectum Other: <b>GONORRHEA (GC) CULTURE</b> Source/site: <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Throat <input type="checkbox"/> Rectum Other: <b>STOOL SPECIMENS</b> History of bloody stools? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Calliculture testing <input type="checkbox"/> Stool culture <input type="checkbox"/> Stool ova & parasite exam <input type="checkbox"/> Stool ova & parasite (high risk, submit 2 samples) <b>DERMATOPHYTES</b> <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: <b>MYCOLOGY</b> <input type="checkbox"/> Yeast <input type="checkbox"/> Fungus Site:		<b>HEPATITIS SEROLOGY</b> <input type="checkbox"/> Acute viral hepatitis undefined etiology Hepatitis A (anti-HAV IgM) Hepatitis B (HBsAg $\pm$ anti-HBc) Hepatitis C (anti-HCV) <input type="checkbox"/> Chronic viral hepatitis undefined etiology Hepatitis B (HBsAg; anti-HBc; anti-HBs) Hepatitis C (anti-HCV) <b>Investigation of hepatitis immune status</b> <input type="checkbox"/> Hepatitis A (anti-HAV, total) <input type="checkbox"/> Hepatitis B (anti-HBs) <b>Hepatitis marker(s)</b> <input type="checkbox"/> HBsAg (For other hepatitis markers, please order specific test(s) below) <input type="checkbox"/> HIV Serology (patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting) <input type="checkbox"/> Non-nominal reporting <b>OTHER TESTS - Standing Orders include expiry &amp; frequency</b> <input type="checkbox"/> ECG <input type="checkbox"/> FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program <input type="checkbox"/> FIT No copy to Colon Screening Program	
<b>CHEMISTRY</b> <input type="checkbox"/> Glucose - fasting (see reverse for patient instructions) <input type="checkbox"/> Glucose - random <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 hour & 2 hour test) <input type="checkbox"/> GTT - non-gestational diabetes <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> Albumin/creatinine ratio (ACR) - Urine <b>LIPIDS</b> <input checked="" type="checkbox"/> 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) <input type="checkbox"/> Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia) <input type="checkbox"/> Follow-up Lipid Profile - Total, HDL, & non-HDL cholesterol only <input type="checkbox"/> Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated) <b>THYROID FUNCTION</b> For other thyroid investigations, please order specific tests below and provide diagnosis: <input type="checkbox"/> Monitor thyroid replacement therapy (TSH Only) <input type="checkbox"/> Suspected Hypothyroidism (TSH first, FT4 if indicated) <input type="checkbox"/> Suspected Hyperthyroidism (TSH first, FT4 & FT3 if indicated) <b>OTHER CHEMISTRY TESTS</b> <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"/> Bilirubin <input type="checkbox"/> Pregnancy test <input type="checkbox"/> GGT <input type="checkbox"/> B-HCG - quantitative <input type="checkbox"/> T-Protein			
DATE OF COLLECTION TIME OF COLLECTION COLLECTOR TELEPHONE REQUISITION RECEIVED BY: (employee/date/time)		SIGNATURE OF PRACTITIONER DATE SIGNED	
Other instructions:			

### 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.