Newfoundland Labrador

1V1820 0177 07 2018

Outpatient Specimen Collection Requisition

HCN:

Province/Territory: ____ Expiry: YYYY / MON / DD

Name: First Middle Surname

Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

Mailing Address:

City: _____ Prov/Terr:____ Postal Code:_ _ _ _ _ _

Telephone: (Indicate Preferred) ☐ Home (_ _ _) - _ _ _ - _ _ _ _

☐ Cell (_ _ _) -_ _ _-_ _ _ _ ☐ Work (_ _ _) - _ _ _ - _ _ _ _

Ordering Provider's Name_____

Clinic Name: _____

Mailing Address_____

City:_____Prov/Terr:_____ Postal Code: _ _ _ _ _ _

Phone: (_ _ _) -_ _ _- _ _ _ _ Fax: (_ _ _) -_ _ _- _ _ _ _

Ordering Provider's Meditech Mnemonic:_____

Signature:_____Date: YYYY / MON / DD

Clinic Stamp:(include fax, provider and mnemonics)

EMR Clinic Mnemonic:_____

COPY TO PROVIDER _____

DIAGNOSIS / RELEVANT HISTORY:

HEMATOLOGY

- ☐ CBC..... (Includes automated differential)
- ☐ PTI ..... INR Anticoagulant _____

IMMUNOHEMATOLOGY

- ☐ BLTYABS ..... Type and Screen

CHEMISTRY

- ☐ GLUFA ..... Glucose (Fast 8hr)
- ☐ GLUCO ..... Glucose – Random (Non-fasting)
- ☐ GTT2H ..... 75 gm OGTT (Fast 8hr)
- ☐ G1HP50GGO ... 50 gm Prenatal Screen (Non-fasting)
- ☐ GTTG ..... 75 gm OGTT (Fast 8hr; for PRE-NATAL use)
- ☐ HBA1CTHB ..... Hemoglobin A1C
- ☐ CR ..... Creatinine (with eGFR)
- ☐ SODIU ..... Sodium
- ☐ POTAS ..... Potassium
- ☐ BILTO ..... Bilirubin, Total
- ☐ ALT ..... Alanine Aminotransferase
- ☐ CALCI ..... Calcium (with Albumin)
- ☐ URATE ..... Uric Acid
- ☐ PROTE ..... Total Protein
- ☐ ALBUM ..... Albumin
- ☐ CREKI ..... Creatine Kinase
- ☐ HEPFUP ..... ALP, ALT (Reflex AST & Total Bilirubin)
- ☐ LIPIDP ..... TChol, HDL, TG, Calculated LDL, non-HDLC
- ☐ TSH ..... Thyroid Stimulating Hormone (Reflex fT4)
- ☐ CRPHS ..... C-Reactive Protein
- ☐ FERRI ..... Ferritin
- ☐ PSA ..... Prostate Specific Antigen (PSA)

Frequency of Testing (For Repeat Testing)_____

THERAPEUTIC DRUG MONITORING

☐ Drug #1:
Date and Time of Last Dose: YYYY /MON / DD HH : MM
Date and Time of Next Dose: YYYY / MON / DD HH : MM

☐ Drug #2:
Date and Time of Last Dose: YYYY /MON / DD HH : MM
Date and Time of Next Dose: YYYY /MON / DD HH : MM

URINE TESTING Antibiotics: _____

- ☐ URINAP..... Urinalysis (reflex microscopic when applicable)
- ☐ HCGU..... Pregnancy Test
- ☐ URINC .....Urine Culture ☐ Symptomatic ☐ Pregnant
  (Urine cultures collected from indwelling catheters will be rejected)
- ☐ MALCRPU.... Albumin/Creatinine Ratio (Microalbumin)

PRENATAL SCREENING

- ☐ BLTYABS ....Type and Screen
- ☐ PNS.....Prenatal Serology (Includes HIV, Rubella, HBSAG, Syphilis Screen)

MICROBIOLOGY

- ☐ HIVS.....HIV Screen ☐ HBSAB.....Hep B Immunity Screen
- ☐ TPALAB.....Syphilis Screen
- ☐ CTNGDP....CT/NG Testing (Swab)
- ☐ CTNGDPU..CT/NG Testing (Urine)
- ☐ HEPDX.....Hepatitis Diagnosis Panel
  (HAV IgM, HBV surface Ag, anti-HBV core total, anti-HCV)

ADDITIONAL REQUESTS: (MUST BE PRINTED LEGIBLY)

If fasting is required - do not eat anything (except medications and/or water) for the time period indicated.
If you need additional information about preparing for your lab test, please contact your local Laboratory Medicine services.

Please note, some tests require an accompanying completed Special Authorization form before the test can proceed.

*DATE & TIME OF COLLECTION: YYYY /MON/ DD HH: MM INITIALS: _____

Clear Form Print Form

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