Eastern Health

Outpatient Specimen Collection Requisition

IV1820 0177 08 2012

*Completion of * fields is mandatory – Patient's name and MCP Number. Practitioners full name, signature and date of request.*

HEALTHCARE CARD (MCP/HCN) MUST BE PRESENTED AT LABORATORY REGISTRATION

If fasting is required – *do not eat or drink anything* (except medications and/or minimal amount of water) for the time period indicated.
If you need additional information about preparing for your lab test, please call 777-6001.

*NAME: _____

* HCN (MCP): _____

HCN EXPIRY DATE: DD/MONTH/YYYY DATE OF BIRTH: DD/MONTH/YYYY

ADDRESS: _____

_____

TELEPHONE: _____

☐ INPATIENT – UNIT _____ ☐ OUTPATIENT

***PHYSICIAN INFORMATION (PLEASE USE STAMP)**

PROVIDE MEDITECH MNEMONIC IF KNOWN

***PHYSICIAN SIGNATURE:** _____

***DATE:** DD/MONTH/YYYY

DIAGNOSIS/RELEVANT HISTORY

Frequency of Testing (For Repeat Testing) _____

COPY TO PROVIDER

HEMATOLOGY
- ☐ CBC..... CBC, includes automated differential
- ☐ PTI..... INR Anticoagulant _____

IMMUNOHEMATOLOGY
- ☐ BLTYABS..... Type and Screen

CHEMISTRY
- ☐ GLUFA.....Glucose (Fasting – 8 hours)
- ☐ GLUCO .....Glucose – Random (No fasting required)
- ☐ GTT.....75 gm OGTT (Fasting; 2 hours PC)
- ☐ G1HP50GGO....50 gm (Non-Fasting;1hour PC PRE-NATAL ONLY)
- ☐ GTTG.....75 gm OGTT (Fasting;1 hour PC; 2 hours PC PRE-NATAL ONLY)
- ☐ HBA1CTHB.....A1C
- ☐ CR.....Creatinine (eGFR)
- ☐ SODIU.....Sodium
- ☐ POTAS.....Potassium
- ☐ CREKI.....Creatine Kinase
- ☐ BILTO.....Bilirubin, Total
- ☐ ALT .....Alanine Aminotransferase
- ☐ CALCI .....Calcium
- ☐ URATE.....Uric Acid
- ☐ PROTE.....Total Protein
- ☐ ALBUM.....Albumin
- ☐ HEPFUP .....ALP, ALT, (Reflex AST & Total Bilirubin)
- ☐ LIPIDP.....TChol, HDL, TG, Calculated LDL, non-HDLC(Fast 12 hours)
- ☐ LIPIDPNF .....TChol, HDL, non-HDL-C (Non-fasting)
- ☐ TSH.....Thyroid Stimulating Hormone (with reflex fT4 and/or fT3)
- ☐ CRPHS .....C-Reactive Protein
- ☐ FERRI .....Ferritin

URINE TESTING **Antibiotics:** _____
- ☐ URINAP..... Urinalysis (reflex microscopic will be performed when applicable)
- ☐ PRETU ……Pregnancy Test
- ☐ URINCU……..Urine Culture
- ☐ MALCPU……..Albumin/Creatinine Ratio

THERAPEUTIC DRUG MONITORING

☐ Drug #1: _____

DD/MONTH/YYYY /Hours — Date and Time of **Last** dose
DD/MONTH/YYYY /Hours — Date and Time of **Next** dose

☐ Drug #2: _____

DD/MONTH/YYYY /Hours — Date and Time of **Last** dose
DD/MONTH/YYYY /Hours — Date and Time of **Next** dose

PRENATAL SCREENING
- ☐ BLTYABS ..... Type and Screen
- ☐ PNS..... ……Prenatal Serology Including HIV/CBC

OTHER TESTING
- ☐ HIVS.....HIV Screen
- ☐ TPALAB .....Syphilis Screen
- ☐ CTNGDP..... CT/NG Testing (Swab)
- ☐ CTNGDPU .....CT/NG Testing (Urine)
- ☐ HEPDX.....Hepatitis Diagnosis Panel
- ☐ HBSAB.....Hep B Immunity Screen

ADDITIONAL REQUESTS: (MUST BE PRINTED LEGIBLY)

Testing may not be performed if the requisition is illegible, required information is missing, or the specimen is mislabeled.

DATE & TIME OF COLLECTION: DD/MONTH/YYYY /Hours *INITIALS:* _____