



1 V1820 0177 07 2018

Outpatient Specimen Collection Requisition

HCN: _____
 Province/Territory: _____ Expiry: _____
 Name: _____
 Date of Birth: _____ Sex: ☐ M ☐ F ☐ UN
 Mailing Address: _____
 City: _____
 Province/Territory: _____ Postal Code: _____
 Telephone: (indicate preferred) ☐ Home: _____
☐ Cell: _____ ☐ Work: _____

Ordering Provider's Name: _____ Clinic's Name: _____ Mailing Address: _____ City: _____ Province/Territory: _____ Postal Code: _____ Telephone: _____ Fax: _____ Signature: _____ Date: YYYY/MON/DD	Clinic Stamp: (include Fax, Provider and Mnemonics) Ordering Provider's Meditech Mnemonic: _____ EMR Clinic Mnemonic: _____ COPY TO PROVIDER:
DIAGNOSIS/RELEVANT HISTORY: 	Frequency of Testing (for repeat testing): _____ THERAPEUTIC DRUG MONITORING ☐ Drug #1 Date and Time of Last Dose: _____ HH:MM Date and Time of Next Dose: _____ HH:MM ☐ Drug #2 Date and Time of Last Dose: _____ HH:MM Date and Time of Next Dose: _____ HH:MM URINE TESTING ☐ URINAP Urinalysis (reflex microscopic when applicable) ☐ HCGU Pregnancy Test ☐ MALCRPU Albumin/Creatinine Ratio (Microalbumin) ☐ URINCUC Urine Culture ☐ Symptomatic ☐ Pregnant (Urine cultures collected from indwelling catheters will be rejected) Antibiotics: _____ PRENATAL SCREENING ☐ BLTYABS Type and Screen ☐ PNS Prenatal Screen (Includes CBC, HIV, Rubella, HBSAG, Syphilis Screen) MICROBIOLOGY ☐ HIVS HIV Screen ☐ TPALAB Syphilis Screen ☐ CTNGDP CT/NG Testing (Swab) ☐ CTNGDPU CT/NG Testing (Urine) ☐ HEPDX Hepatitis Diagnosis/Screening Panel (B and C) ☐ HAVABM Acute Hepatitis A Testing ☐ HBSAB Hepatitis B Immunity ADDITIONAL REQUESTS (MUST BE PRINTED LEGIBLY)

HEMATOLOGY

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

IMMUNOHEMATOLOGY

- ☐ BLTYABS Type and Screen

CHEMISTRY

- ☐ GLUFA Glucose (fast 8 hours)
☐ GLUCO Glucose – Random (non-fasting)
☐ GTT2H 75 gm OGTT (fast 8 hours)
☐ G1HP50GGO 50 gm Glucose (non-Fasting)
☐ GTTG 75 gmOGTT (fast 8 hours for PRE-NATAL use)
☐ HBA1CTHB Hemoglobin A1C
☐ EGFR 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 and 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)

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, contact your local Laboratory Medicine Services.
Note: Some tests require an accompanying completed Special Authorization form before the test can proceed.

Date and Time of collection: _____ Collector's Signature: _____
 Collector's Notes: _____