



Laboratory Requisition

This requisition form, when completed, constitutes a referral to LifeLabs laboratory physicians. It is for the use of authorized health care providers only.

THIS AREA IS FOR LAB USE

COMPLETE and ACCURATE information is required in all shaded areas.

Patient Surname (from CareCard) KISSOCK		First JAGODA	Initial(s)	Date of Birth 23 / 05 / 1985	Sex <input type="checkbox"/> F <input type="checkbox"/> M
Bill to: <input checked="" type="checkbox"/> MSP <input type="checkbox"/> CBC <input type="checkbox"/> WorkSafeBC <input type="checkbox"/> Patient <input type="checkbox"/> Other		Chart Number		Room # (LTC use only)	
PHN		I.D. Number			
Patient Address BC, Canada		City, Province		Postal Code	
Ordering Physician, Address, MSP Practitioner Number Dr. Jagoda Kissock 62567 #902 - 13737 96th Ave Surrey BC, Canada V3V 0C6		Locum for: Physician MSC #	C0 Number	Patient Telephone Number (000) 000-0000 (000) 000-0000	
Copy to: Address, MSP Practitioner Number Dr.		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fasting <input type="checkbox"/> hours prior to test	<input type="checkbox"/> Phone <input type="checkbox"/> Fax	Date/Time of Collection Phlebotomist Data Entry	
		Diagnosis and indications for guideline protocol and special tests		Date/Time/Name of Medication	
		Telephone Requisition Received By:		INITIAL/DATE	

For tests indicated with a shaded tick box ☒, consult provincial guidelines and protocols (www.BCGuidelines.ca)

HEMATOLOGY <input type="checkbox"/> Hematology profile <input type="checkbox"/> PT-INR <input type="checkbox"/> On Warfarin? <input type="checkbox"/> Ferritin (query iron deficiency) 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)	CHEMISTRY <input type="checkbox"/> Glucose - fasting (see reverse for patient instructions) <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 & 2 hour test) <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> Albumin/creatinine ratio (ACR) - Urine																
LIPIDS <input checked="" type="checkbox"/> One box only. For other lipid investigations, please order under Other Tests section and provide diagnosis. <input type="checkbox"/> Baseline cardiovascular risk assessment or follow-up (Lipid profile, Total, HDL, non-HDL & LDL Cholesterol, Triglycerides, fasting) <input type="checkbox"/> Follow-up of treated hypercholesterolemia (Total, HDL & non-HDL Cholesterol, fasting not required) <input type="checkbox"/> Follow-up of treated hypercholesterolemia (ApoB only , fasting not required) <input type="checkbox"/> Self-pay lipid profile (non-MSP billable, fasting)	THYROID FUNCTION <input checked="" type="checkbox"/> One box only. For other thyroid investigations, please order under Other Tests section and provide diagnosis. <input type="checkbox"/> Monitor thyroid replacement therapy (TSH Only) <input type="checkbox"/> Suspected Hypothyroidism TSH first (plus FT4 if required) <input type="checkbox"/> Suspected Hyperthyroidism, TSH first (plus FT4 or FT3 if required)																
OTHER CHEMISTRY TESTS <table border="0"> <tr> <td><input type="checkbox"/> Sodium</td> <td><input type="checkbox"/> Creatinine/eGFR</td> </tr> <tr> <td><input type="checkbox"/> Potassium</td> <td><input type="checkbox"/> Calcium</td> </tr> <tr> <td><input type="checkbox"/> Albumin</td> <td><input type="checkbox"/> Creatine kinase (CK)</td> </tr> <tr> <td><input type="checkbox"/> Alk phos</td> <td><input type="checkbox"/> PSA - Known or suspected prostate cancer (MSP billable)</td> </tr> <tr> <td><input type="checkbox"/> ALT</td> <td><input type="checkbox"/> PSA screening (self-pay)</td> </tr> <tr> <td><input type="checkbox"/> Bilirubin</td> <td><input type="checkbox"/> Pregnancy Test</td> </tr> <tr> <td><input type="checkbox"/> GGT</td> <td><input type="checkbox"/> Serum <input type="checkbox"/> Urine</td> </tr> <tr> <td><input type="checkbox"/> T. Protein</td> <td></td> </tr> </table>		<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"/> Serum <input type="checkbox"/> Urine	<input type="checkbox"/> T. Protein	
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MICROBIOLOGY LABEL ALL SPECIMENS WITH PATIENT'S FIRST AND LAST NAME, DOB AND/OR PHN & SITE ROUTINE CULTURE List current antibiotics: <input type="checkbox"/> Throat <input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> Superficial Wound Site: _____ <input type="checkbox"/> Deep Wound Site: _____ <input type="checkbox"/> Other: _____ VAGINITIS <input type="checkbox"/> Initial (smear for BV & yeast only) <input type="checkbox"/> Chronic/recurrent (smear, culture, trichomonas) <input type="checkbox"/> Trichomonas testing GROUP B STREP SCREEN (Pregnancy only) <input type="checkbox"/> Vagino-anorectal swab <input type="checkbox"/> Penicillin allergy CHLAMYDIA (CT) & GONORRHEA (GC) <input type="checkbox"/> CT & GC Testing Source/site: <input type="checkbox"/> Urethra <input type="checkbox"/> Cervix <input type="checkbox"/> Urine <input type="checkbox"/> GC culture: <input type="checkbox"/> Throat <input type="checkbox"/> Rectal <input type="checkbox"/> Other: _____ STOOL SPECIMENS History of bloody stools? <input type="checkbox"/> Yes <input type="checkbox"/> C. difficile testing <input type="checkbox"/> Stool culture <input type="checkbox"/> Stool ova & parasite exam <input type="checkbox"/> Stool ova & parasite (high risk, 2 samples) DERMATOPHYTES <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: _____ MYCOLOGY <input type="checkbox"/> Yeast <input type="checkbox"/> Fungus Site: _____

URINE TESTS <input type="checkbox"/> Urine culture - list current antibiotics: <input type="checkbox"/> Macroscopic \rightarrow microscopic if dipstick positive <input type="checkbox"/> Macroscopic \rightarrow urine culture if pyuria or nitrite present <input type="checkbox"/> Macroscopic (dipstick) <input type="checkbox"/> Microscopic <input type="checkbox"/> Special case (if ordered together)
HEPATITIS SEROLOGY <input checked="" type="checkbox"/> One box only. For other Hepatitis Markers, please order under Other Tests section. <input type="checkbox"/> Acute viral hepatitis undefined etiology Hepatitis A (anti-HAV IgM) Hepatitis B (HBsAg, plus anti-HBc if required) Hepatitis C (anti-HCV) <input type="checkbox"/> Chronic viral hepatitis undefined etiology Hepatitis B (HBsAg, anti-HBc, anti-HBs) Hepatitis C (anti-HCV) Investigation of hepatitis immune status <input type="checkbox"/> Hepatitis A (anti-HAV, total) <input type="checkbox"/> Hepatitis B (anti-HBs) <input type="checkbox"/> Hepatitis marker(s) HBsAg
HIV SEROLOGY <input type="checkbox"/> HIV Serology (patient has legal right to choose not to have their name and address reported to public health - non-nominal reporting) <input type="checkbox"/> Non-nominal reporting
OTHER TESTS <input type="checkbox"/> ECG <input type="checkbox"/> Fecal Occult Blood (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program. <input type="checkbox"/> Fecal Occult Blood (other indications)
CBC, lytes, Cr, A1c, ALT, AST, LDL, HDL, trigs, non-HDL, FSH, LH, Estradiol, Total testosterone, 25OH vitamin D q3months x 1 year

The personal information collected on this form and any medical data subsequently developed will be used and disclosed only as permitted or required by the Personal Information Protection Act (and related acts and regulations) of British Columbia. LifeLabs privacy policy is available at www.lifelabs.com. Use of this form implies consent for the use of de-identified patient data and specimens for quality assurance purposes.

Date
February 03, 2025
Requisition is valid for one year from the date of issue.

Physician Signature

Standing Order requests - expiry and frequency must be indicated